IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4044 7489

March 11, 2013

Tracy Schaner, Acting Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501

Provider #: 135133

Dear Ms. Schaner:

On **February 20, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Idaho State Veterans Home - Lewiston by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **isolated** deficiencies and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **February 15, 2013**.

On **February 15, 2013**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and

state the date when each will be completed. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 25, 2013**. Failure to submit an acceptable PoC by **March 25, 2013**, may result in the imposition of additional civil monetary penalties by **April 15, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

    a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

    b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

    c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy cited during this survey;

F225 -- S/S: J --42 CFR §483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/Report Allegations/Individuals
F226 -- S/S: J -- 42 CFR §483.13(c) -- Develop/Implement Abuse/Neglect, etc, Policies

We are recommending to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **$5000.00**.
(*THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510*) (§488.430)

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 20, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F225 -- S/S: J -- 42 CFR §483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/Report Allegations/Individuals;

F226 -- S/S: J -- 42 CFR §483.13(c) -- Develop/Implment Abuse/Neglect, etc Policies

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **10, 16 and 17** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

STATE ACTIONS effective with the date of this letter (**March 11, 2013**): None

If you believe the deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **March 25, 2013**. If your request for informal dispute resolution is received after **March 25, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. BUILDING _____ B. WING _____	C 02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - LEWISTON	821 21ST AVENUE LEWISTON, ID 83501

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F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. Immediate Jeopardy was identified at F225 and F226. The facility was notified in writing on 2/15/13 at 8:45am. The Immediate Jeopardy was abated on 2/15/13 at 2:15 pm. The surveyors conducting the survey were: Lynda Evenson, BSN, RN - Team Coordinator Nina Sanderson, BSW, LSW Ashley Anderson, QMRP Lorraine Hutton, RN Survey Definitions: ADL = Activities of Daily Living BFS = Bureau of Facility Standards CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment TAR = Treatment Administration Record	F 000	Annual Survey completed on February 20, 2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, record	F 155	F155 RIGHT TO REFUSE, FORMULATE ADVANCED DIRECTIVES This requirement was not met as evidenced by the determination that the facility failed to ensure a resident's advanced directives clearly indicated the resident/legal representative's choice regarding tube feeding and IV fluid administration. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #14 no longer resides at the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

NHA Acting Home Administrator 3/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 review and staff interview, it was determined the facility failed to ensure a resident's advance directives clearly indicated the resident/legal representative's choice regarding tube feeding and IV (Intravenous) fluid administration. This affected 1 of 11 residents (Resident #14) reviewed for advance directives. This failed practice had the potential to interfere with the resident/legal representative's right to choose end of life treatment. Findings include: A complaint received by the Bureau of Facility Standards on 2/11/13 documented that the POST [Physician's Order for Scope of Treatment] was changed by Resident #14's family during a hospitalization on 12/2/11. The complainant stated the family approved tube feeding, IV, and antibiotics. The complainant stated the resident's medical records, sent to another skilled nursing facility during a transfer of care, "Was different" [than what the family had indicated they wanted] and the changes were not signed or initialed. The complainant believed the POST was wrongfully altered by the facility. Resident #14 was admitted to the facility on 11/2/12 with diagnoses including traumatic brain injury which occurred 24 years ago, seizure disorder, quadriplegia, chronic nonunion right hip fracture, neurogenic bladder and bowel, reoccurring pneumonia and urinary tract infections. A Social Services Progress Note, dated 11/2/12, documented. "[Resident #14] arrived today by ambulance... Family is filling out new POST to reflect 'No Code' today. [Resident #14] has his father and 3 sisters as legal guardians..." Note:	F 155	2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility have the potential of being affected by the deficient practice. Social Services will audit 100% of the current resident charts at ISVH-L to determine that the POST is filled out correctly and will obtain new POST's for residents as needed. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Admissions Coordinator and Social Services Personnel have been in-serviced to the revised Advanced Directives procedure, how to correctly complete a POST, how to properly process a POST and what documentation is required in the resident's medical record. The Advanced Directives procedure for ISVH-L has been updated and indicates that prior to or upon admission of a resident, the Admissions Coordinator or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. The information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Advanced Directives procedure for ISVH-L has been updated to reflect that with any changes or revocations of a POST directive then a new POST will be completed by a member of the Interdisciplinary team and submitted to the residents attending physician. Changes will be identified to the Interdisciplinary team and then those changes will be reflected in the resident' s medical record, care plan, assessment and Social Work documentation. Additionally, the POST will be reviewed annually with the resident or their representative by Social Services during the resident's Annual assessment process and recorded in the resident's Social work annual assessment.	

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F 155	Continued From page 2 The resident's 11/8/12 MDS assessment coded a 3 under cognitive patterns (C 0100 - 0400) indicating the resident was severely cognitively impaired. Two POST forms were found in Resident #14's closed medical record. Both were dated 11/2/12 and were signed by the resident's father and the resident's physician. The signatures and dates on the two forms appeared identical. However, Section C of one of the forms was blank under the "Artificial Fluids and Nutrition and Antibiotics and Blood Products" section and was marked for feeding tubes and antibiotics on the second form. The 11/2/12 admission physician's orders documented 'No Code'. Nurses Notes, dated 12/2/12, and a hospital Discharge Summary dated 12/13/12, documented Resident #14 was transferred to the hospital for pneumonia and sepsis on 12/2/12 and returned to the facility on 12/13/12. On 12/14/12 the resident's physician wrote, "[Resident #14] now has a peg tube (previously we were told by family that he could not tolerate a peg tube)... His family is very active in his care and decision making and there is some controversy among family members concerning advance directives... I would like the family to take a look at his POST and give us an up to date consensus on their wishes..." No documentation was found in the records provided by the facility that explained the difference in the two POSTs dated 11/2/12, which of the two POSTs was to be implemented in an emergency, and/or the facility's response to the physician's request to clarify/obtain a consensus	F 155	CQI -Advanced Directives has been developed to monitor resident Advanced Directive completion, annual review, medical record documentation and care planning of the directive. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. ISVH-L Administrator or her designee will monitor the CQI-Advanced Directives This CQI will be done every two weeks x one month, then monthly x 3 months then biannually. This CQI will be started on March 25, 2013 5. Date Corrective action will be completed: April 15, 2013	

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F 155	Continued From page 3 regarding the family's "wishes." During a telephone conference on 2/28/13 at 9:40 am, the Acting Administrator, the Acting DNS, and a consulting social worker were asked to clarify the discrepancy between the two POST forms dated 11/2/12 and to clarify which form was accurate. In addition, they were asked to provide documentation indicating the physician's concerns of 12/14/12 were addressed. On 3/1/13, the facility faxed addition documentation which included the following: * Social Service Progress Notes dated 12/18/12 which documented, "[Resident #14] was readmitted on 12/13/12.... phoned [Sister A] re POST which states comfort measures... but MD [physician] notes indicate aggressive measures. [Sister A] prefers [Sister B] be contacted. Left message with [Sister B] to call back to make sure POST is what family/guardians want. * Social Service Progress Notes dated 12/19/12 which documented, "[Sister B] returned call this morning. Reviewed POST with [Sister B] which is to continue as is - she and her father would not want aggressive interventions, they would want ABOs [antibiotics] and [Resident #14] has a feeding tube. Also reviewed the information with RN manager. POST continue as is - 'NO CODE'." * A typed addendum to the 12/18 and 12/19 Social Service Progress Notes, dated 3/1/13 and signed by the current social worker, that documented, "I placed a phone call to [Sister A] to review [resident's] POST. [Sister A asked that I contact her sister, [Sister B] also a guardian.... [Sister B] returned my call on 12/19/12. I reviewed [the resident's] POST, reading each section to [Sister B] and indicating what was already	F 155		

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F 155	Continued From page 4 marked. [Sister B] indicated wanting NO CODE to continue and comfort measures to continue. [Sister B] asked that the feeding tube and antibiotics be indicated on [Resident #14's] POST. I marked these 2 sections with an X while on the phone.... I did however omit initialing and dating these two changes. At the time I did make a note in [resident's] chart and reviewed changes with RN manager. During a telephone interview on 3/4/13 at 10:39 am, the Acting DNS explained that Resident #14 initially came to the facility on 11/2/12 as a 'Full Code'. The social worker was told the family wanted to change the resident to a 'NO CODE' and assisted them with the paper work. The resident's father and the resident's physician signed a POST on 11/2/12 which was not marked for tube feeding or antibiotics. In response to the physician's concerns about the family's 'wishes', the social worker contacted family members on 12/18/12 and 12/19/12. The social worker modified (marked with an 'X') the 11/2/12 POST to indicate the family's wishes for both tube feeding and antibiotics but failed to initial or date the modifications. The Acting DNS stated that she suggested to the facility that they start a new process/form, in the future, when a POST needs to be modified. During the 3/4/12 telephone interview the Acting DNS was notified of the unresolved concerns with the lack of clarity of the POST forms dated 11/2/12. No further information or documentation was provided that resolved the concerns.	F 155		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167	F 167 RIGHT TO SURVEY RESULTS- READILY ACCESSIBLE	

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F 167	Continued From page 5 A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a copy of the most recent federal and state survey was made available for resident review for all residents (Residents #1 - 61) at the facility. This had the potential to infringe on the rights of the residents to be informed of survey results. The findings include During an environmental review of the facility on 2/13/13 from 10:00 - 10:15 a.m., it was noted there was no copy of the most recent results of the federal or state survey available for resident review. CFR 483.10(g) states " A resident has the right to-(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and ... " When asked about the availability of the survey	F 167	This requirement was not met as evidenced by the determination that the facility failed to ensure a copy of the most recent federal and state survey was made available for the resident review for all residents in the facility. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Immediate steps were taken during the survey to locate the survey book. The survey book was located on 2/13/13 at 11:15am and shown to the survey team. The Survey results binder was replaced to its usual location under the bulletin board located in the facility's front entry way. The survey book was noted by staff to have been temporarily moved due to construction in the facility. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. The Survey results binder has been secured to the shelf in the facility's front entry way so that it cannot be removed from this location 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. The most recent Federal and State Survey has been placed in a binder located in the facility front entry way. On March 12, 2013 this binder was secured to this location so that it cannot be easily removed from the area. CQI Facility Environment has been modified to include item to audit this binder to ensure that the most recent survey results are in the binder and that the binder is available for resident review. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.	

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F 167	Continued From page 6 results on 2/13/13 at 11:11 a.m., the Social Worker stated the survey results were usually in a binder under the bulletin board located in the facility entryway. However, the Social Worker could not find them there. On 2/13/13 at 11:15 a.m., the Social Worker brought the survey results binder to the surveyors and stated she found the binder in the chart room. The facility failed to ensure the federal and state survey results were available for resident review.	F 167	The Administrator will monitor the CQI Facility Environment This CQI will be done q week x 4 weeks, then q month x 3 months, then every three months. The CQI will start March 25, 2013 5. Date Corrective action will be completed: April 15, 2013	
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty or abusing, neglecting or mistreating residents by a court of law; or have had an findings entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authority. The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident's property are reported immediately to the administrator of the facility and to other officials according to State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the	

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F 225	Continued From page 7 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policy, review of investigations, review of personnel files, record review, and staff interview, it was determined the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were immediately reported, residents were immediately protected, allegations were thoroughly investigated, and appropriate corrective action was taken. That failure directly impacted 3 of 17 residents (Residents #10, #16 and #17) involved in significant incidents. This resulted in placing Resident #17 in immediate jeopardy with potential for serious harm or impairment due to ongoing abuse. Additionally, this resulted in the potential for on-going abuse and mistreatment to occur to Residents #10 and #16 without immediate protection and notification, thorough investigations and appropriate corrective action being taken. The findings include:	F 225	administrator or his designated representatives and to other officials in accordance with State law (including State survey and certification agency) within 5 working days of the incident and if the alleged violations is verified appropriate corrective action must be taken 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 10, #16 and #17 were affected by this deficient practice. Based on review of the facility' s abuse policy, review of investigations, review of personnel files, record review and staff interviews it was determined that the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were immediately reported, residents were immediately protected, allegations were thoroughly investigated and appropriate corrective action was taken. Staff employed at the Idaho State Veterans Home - Lewiston who were involved with the alleged abuse of residents #10, #16 and #17 were placed on administrative leave while thorough investigations were conducted. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential to be negatively impacted by this deficient practice. As a result, the Idaho State Veterans Home - Lewiston nursing procedure concerning Resident Abuse/Neglect (now called Reasonable Suspicion of a Crime Against a Resident) has been revised to ensure consistency with Administrative Policy, State, and Federal Regulations. All of the staff was in-serviced regarding the deficient practice on February 28, 2013 and March 20, 2013 via multiple all staff meetings. Nursing staff received additional in-services on March 6, 7 & 8, 2013 and through silent in-services. All new allegations of abuse, neglect or mistreatment have been reported to State survey and	

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F 225	Continued From page 8 1. The facility's Resident Abuse/Neglect policy, undated, defined verbal abuse as "any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance to describe residents, regardless of their age, ability to comprehend or disability." Additionally, sexual abuse "includes, but is not limited to, sexual harassment, sexual coercion or sexual assault." a. On 2/14/13 at 12:40 p.m., four investigations from the past year were chosen at random for review. A Report of Investigation, undated, contained an allegation of abuse against LN # 19 to Resident #17 on 8/5/12. The statement from CNA #8, undated, stated "I witnessed a situation between [Resident #17] and [LN #19]. I saw and heard [Resident #17] yelling at someone at the Nurse's station...When I approached the Nurse [sic] station I saw [LN #19] standing outside of the Nurse [sic] station...she was laughing very loud and was taunting and mocking [Resident #17]. [Resident #17] was yelling back at her and called her a 'f***ing b***ard' and threw an ice bag he had wrapped around his neck at her and saying to [LN #19] "stick it up your a*s" and gave her the middle finger. [LN #19] just laughed at him even louder and told [Resident #17] 'that she doesn't like to do it that way'...There were 2 other [LN]'s at the Nurse's station [LN #6] who was sitting charting and [LN #9]...neither of them interviend [sic] or looked up." On 2/14/13 from 3:05 - 3:30 p.m., CNA #8 was asked about the 8/5/12 incident. CNA #8 stated she reported the incident verbally to the DON on 8/6/12 or 8/7/12. CNA #8 stated the DON requested that it be put in writing, which she	F 225	certification agency. All individuals involved in the abuse allegation have been placed on administrative leave pending the outcome of the investigations. Results of the investigation have been reported to the State survey and certification agency. The Director of Social Services from Boise has conducted resident interviews of approximately 50% of the residents to identify concerns of abuse, neglect or mistreatment. No new issues were identified during this process. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All staff have been in-serviced regarding the updated policy and the behavioral expectations of reporting any alleged abuse, neglect or mistreatment of residents. Leadership has been transitioned to an interim staff to ensure the appropriate identification and investigation of alleged complaints of abuse, neglect or mistreatment. Future leadership will be extensively in-serviced regarding the behavioral expectations for reporting abuse allegations to all the appropriate agencies as well as to Division Headquarters staff to ensure that reporting requirements are met. Any identified failures to report abuse according to policy will be address as a performance issue with staff. Residents with behavioral concerns will have a behavior management plan and silent in-services will be used to reeducate the staff on behavior modification techniques. Staff has been in-serviced to the updated behavioral management plans for effective implementation. Social Service has had their policy manual extensively revised to address the current practice and expected professional practice. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.	

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F 225	Continued From page 9 completed and gave to the DON between 8/7/12 and 8/9/12. On 2/14/13 from 4:10 - 4:56 p.m., the DON stated she talked with LN #19 before this incident and told her if she needed help redirecting Resident #17, to let her know. The Report of Investigation did not include any information related to LN #6 and LN #9 or the DON. b. The Report of Investigation contained documentation of seven employee interviews conducted by LSW #1, undated and untimed. The interviews documented that employees were aware and reported to management staff, LN #19's ongoing abuse of Resident #17 with no action being taken by the facility, as follows: - Worker #1 stated " ...she's caught [LN #19] cussing at [Resident #17] in the past and had to step in to actually redirect [LN #19]. She notes [LN #19] continues to do things which taunt [Resident #17]... This particular staff member notes they have warned [LN #19] about her actions to no avail." - "Worker #2 noted much of the same above...worker #2 [sic] stated [LN #19] will flirt with [Resident #17] and then tell him to leave her alone when he wants to continue the contact...When asked, worker #2 noted name-calling, the flirting, and the off-hours spent between [Resident #17] and [LN #19] as being very unprofessional." The documentation of Worker #2 ' s interview did not include specific names called, what Worker #2 meant by " flirting	F 225	The interventions and in-servicing by the interim staff have created an environment in which abuse allegations are reported by all staff. Future leadership staff will be extensively in-serviced to ensure understanding of the policy and all behavioral expectations included in the policy. Idaho Division of Veterans Services staff will monitor this process on a monthly basis for the next 12 months through review of the reported polices, staff interviews, and review of documentation to ensure policies are followed and abuse allegations are reported. 5. Date Corrective action will be completed: April 15,2013	

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F 225	Continued From page 10 " , and it could not be determined what exactly took place during those " off-hours. " - "Worker #3" stated the only thing she had witnessed was the 'Cat & Mouse' game between "[Resident #17] and [LN #19]." The documentation of Worker #3 ' s interview did not include any additional information describing the " cat & mouse " game. - "Worker #4 was relieved to be talking about this issue of [Resident #17] and [LN #19] and noted frustration over past attempts at getting someone to do anything about this. She spoke of this relationship/issue going back at least a year and a half and noted other co-workers trying to tell [LN #19] or warn her of her inappropriate actions with him...She states [LN #19] gets very obnoxious when others try and warn her of her actions and will often yell, cuss, or just make things harder on the aids [sic]. She also stated she and others have said things to management but, still are [sic] no changes in [LN #19]'s behaviors. She notes [LN #19] appears to love the attention and drama she gets from [Resident #17]. She also reportedly jokes in inappropriate and vulgar ways. When asked for an example, she noted [LN #19] and [Resident #17] will speak about sexual things/acts. [LN #17] is said to have been having one of these conversations with [Resident #17] when she left the room saying, "You couldn't please me." She also spoke of the other extreme where [LN #19] is now threatening to harm [Resident #17] if he doesn't leave her alone. More specifically, [LN #19] was overheard telling [Resident #17] she would break his hand if he didn't get away from her. She's also been heard telling [Resident #17] how he ' disgusts	F 225		

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her. ' On another occasion [LN #19] was heard telling [Resident #17] how he ' stinks ' while she was caring for him. Worker #4 is concerned with all the attention being given to [Resident #17] for his behaviors when she finds [LN #19] to be at fault for encouraging the relationship with such inappropriate behavior in the first place." The interview did not contain documentation of which management staff Worker #2 had reported to in the past.

- "Worker #5 was very upset over the lack of attention from management regarding this particular issue. They noted the problems with [LN #19] and [Resident #17] have been going on for well over a year and there have been no noticeable changes in [LN #19]'s behavior. Because of this, many staff have simply given up on the idea of management taking notice and have quit reporting. Also noted by worker #5 [sic] were the many times [LN #19] would come to work early just to sit with [Resident #17] in his room. The conversations were noted as being flirtatious and inappropriate but warnings from staff were said to be ignored by [LN #19]...Worker #5 reports if [LN #19] isn't flirting with [Resident #17] she's calling him an 'a*s' or some other name, yelling at him to get away from her even though he's not purposefully seeking her attention, or just taunting him with gestures and looks. These things are said to have often left [Resident #17] crying and feeling confused."

- "Worker #7 was very reluctant to speak with this worker and at one point asked if she and others were going to lose their jobs over this relationship between [Resident #17] and [LN #19]. When asked why anyone would be fired, worker #7 [sic]

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F 225	Continued From page 12 stated people have been afraid to speak up for fear of retaliation by other nurses in charge or even management who, 'clearly like [LN #19]. ' When asked what she meant by management, worker #7 [sic] gave the names of [DON] and [RN Manager]...She spoke of the relationship between [Resident #17] and [LN #19] as being wrong and weird. She said it's been totally unprofessional from one extreme to the other. She explained that [LN #19] would spend hours sitting in [Resident #17]s [sic] room with him after her shift was over. They'd laugh and talk about getting married and having children together. She said they'd do this in the common area as well as if [LN #19] needed other people to know [Resident #17] was in love with her. She then noted how [LN #19] would be totally opposite and just get mean with [Resident #17] to the point he would cry." On 2/15/13 from 9:18 - 9:38 a.m., the RN Manager stated her staff would casually tell her that the relationship between Resident #17 and LN #19 was inappropriate, but no one ever came to her directly with " grave concerns. " On 2/14/13 from 4:10 - 4:56 p.m., the DON stated talked with LN #19 before and told her if she needed help redirecting Resident #17, to let her know. On 2/14/13 from 4:10 - 4:56 p.m., the Administrator stated she was unaware of the allegation against LN #19 until the statement written by CNA #8 was placed on her desk on 8/15/12. c. The Report of Investigation did not document	F 225		

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how Resident #17 was protected from ongoing abuse. Additionally, during the course of the survey, staff were interviewed about LN #19 with the following results:

- Employee #14 stated LN #19's family member was a resident at the facility and LN #19 still visited him. She said that when LN #19 visited, Resident #17 cried and got very upset. Employee #14 requested that arrangements be made for LN #19 to visit her family member in a private area, but nothing was done with her request.

- Employee #20 stated at one point, Resident #17 was put on suicide watch due to the interactions with LN #19. She stated since LN #19's employment ended, LN #19 had been back to the facility to visit her family member and continued to tease Resident #17 in a sexual nature. Employee #20 said she reported multiple times to the DON that LN #19 was responsible for the inappropriate relationship, but nothing was done.

- Employee #13 stated LN #19 had visited the facility to visit her family member one or two times since her employment with the facility ended, and the visits upset Resident #17.

- LSW #1 stated during an interview on 2/14/13 from 6:15 - 6:40 p.m., he had not witnessed firsthand LN #19 ' s post-employment visits, but had received reports that Resident #17 was upset for quite some time after LN #19 visited the facility. LSW #1 stated LN #19 should have guidelines or supervision in place to visit, but as far as he knew, she did not.

- LSW #2 was interviewed on 2/15/13 from 9:39 -

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F 225	Continued From page 14 10:57 a.m. LSW #2 stated she had heard that Resident #17 was tearful during LN #19 ' s continued visits to the facility. LSW #2 stated when LN #19 was not visiting; Resident #17 was in good spirits. LSW #2 stated she was unaware of any guidelines for LN #19 to make arrangements to visit the facility and stated she herself, did not have any responsibilities if LN #19 visited (such as notifying the Administrator, escorting LN #19, etc.). - The RN Manager stated, during an interview on 2/15/13 from 9:18 - 9:38 a.m., her staff would casually tell her that the relationship between Resident #17 and LN #19 was inappropriate, but no one ever came to her directly with " grave concerns. " - The Administrator stated, during an interview on 2/14/13 from 4:10 - 4:56 p.m., in the past she heard staff occasionally say, " [Resident #17] ' s going to see [LN #19], " however, she was unaware of the extent of the situation until the Report of Investigation was completed in August 2012. Further, the Administrator said she was responsible for placing employees on administrative leave through communication with Human Resources and allowing LN #19 to continue working during the course of the investigation was her decision. d. The Report of Investigation documented the investigation was not initiated until 8/21/12. No explanation for the time delay between the 8/5/12 incident until the initiation of the investigation could be found. e. The Report of Investigation did not include	F 225		

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F 225	Continued From page 15 documentation that Resident #17, the DON and the RN Manager were interviewed. f. The allegation of abuse by LN #19 was not reported to the Bureau of Facility Standards as required in Informational Letter #2005-1. g. The Report of Investigation did not include evidence that corrective action was taken with all employees including management staff who were aware of LN#19's ongoing abuse to Resident #17. Review of LN #19 ' s personnel file showed that LN #19 was terminated 9/6/12 due to the results of the investigation. Finally, employees of the facility including management staff (who were aware of LN#19's ongoing abuse to Resident #17 during her employment) were also aware of LN #19's current contact with Resident #17 during her visits. The survey team read, and provided in writing, the following statement on 2/15/13 at 8:45 a.m.: " During an Idaho State recertification survey, initiated 2/11/13 a deficient practice was identified at 483.13(c)(2), 483.13(c)(3), 483.13(c)(4) 483.13(c). This failed practice resulted in serious harm constituting immediate jeopardy. The Idaho State survey team determined the facility failed to protect a resident from further abuse when they allowed a facility staff member, who was terminated for the abuse, enter the facility without structured guidelines and/or supervision. The staff member was allowed to visit a family member and former co-workers without protecting the resident from abuse. In addition, the facility failed to investigate, thoroughly and immediately, all allegations of abuse, protect the resident during the	F 225		

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investigation, and report the allegation and the investigation to the appropriate agencies as required.
These failed practices were brought to the attention of the facility Administrator and Director of Nursing on 2/15/13 at 0845. The facility was provided specific details of these failures.
Idaho State Veteran ' s Home - Lewiston should begin immediate removal of the risk to individuals and immediately implement corrective measures to prevent repeat jeopardy situations. "
The document was signed by the survey team, the Administrator, and the DON.
NOTE: An acceptable Plan of Correction was submitted on 2/15/13 at 2:15 p.m. and the immediate jeopardy was abated.

2. An Incident Investigation, undated, summarized an investigation conducted from 8/13/12 - 8/15/12 regarding an allegation of abusa on Resident #16, during a shower on 8/1/12 by LN #19 and CNA #20. Resident #16 ' s Resident Facesheet, undated, documented a 91 year old male whose diagnoses included Alzheimer ' s disease.

a. LN #19 was placed on administrative leave 8/14/12 for protection of the residents, however, CNA #20 was not.

When asked during an interview on 2/19/13 from 2:50 - 3:12 p.m., the Administrator stated CNA #20 was not placed on administrative leave because once statements clarifying the allegation were received, the focus was placed on LN #19.

b. CNA #3 witnessed the shower on 8/1/12 and reported the incident to LN #4 on 8/12/13. LN #4

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then reported the incident to the Administrator on 8/13/13. However, the Incident Investigation did not contain documentation that CNA #3 or LN #4 were retrained on the abuse policy, including immediate protection of residents or immediate reporting.

When asked, the Administrator stated during an interview on 2/19/13 from 2:50 - 3:12 p.m. she carried a facility phone 24 hours a day, seven days a week to facilitate immediate reporting. She stated she would check personnel files for documentation of the abuse policy, however, the facility failed to provide any additional documentation.

3. Resident #10 was admitted to the facility on 6/10/09 with multiple diagnoses including dementia and depression.

The resident's most recent quarterly MDS assessment, dated 10/15/12, coded:
* Understood and usually understands
* BIMS of 9 indicating moderately impaired cognitive skills for daily decision making
* No signs or symptoms of delirium present
* Physical behavioral symptoms directed toward others occurred 1 to 3 days during the 7 day look back period
* Verbal behavioral symptoms directed toward others occurred 4 to 6 days during the 7 day look back period
* Mood score for depression was zero indicating no signs or symptoms of depression during the 14 day look back period

Resident #10's Physician Orders for 2/2013 documented the resident received Depakote 750

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F 225	Continued From page 18 milligrams by mouth 3 times a day for "1) Verbal and physical aggression 2) Irritability and angry outbursts" and "3) Refusing cares, bathing & treatments..." Resident #10's Plan of Care documented the problem, dated 6/18/09, "AIA [unknown]." Interventions included, "...Provide opportunity for communication/socialization during each contact." Under the problem, "Ineffective individual coping," dated 6/10/09, interventions included, "...1:1, diversional activities ...validation, redirection. " On 12/13/12, a Social Services Progress Notes entry (untimed), recorded by LSW #1, documented, "Staff have shared info[rmation] about [Resident #10] having had a verbal altercation w/staff [with staff] during dinner last night [12/12/12]. He separately threatened physical harm and the staff responded inappropriately, but then walked away. ...Social Services will speak with & remind him of not only the consequences of his action but his responsibility to respect staff and other residents." A second untimed note, recorded on 12/13/12 by LSW #1, documented, "Spoke w/[Administrator's name] who agreed [Resident #10] has now escalated his verbal abuse to physical threats [with] staff. With 2 staff having reacted as shared their inability to cont[inue] working or under this abuse, it may be time to look at transferring [Resident #10] to another facility. ..." During an interview with Employee #20 (E-20), the employee was asked about abuse, in general, in the facility. E-20 said that sometime recently, at	F 225		

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F 225	Continued From page 19 least during the last year, E-20 knew about verbal abuse between Resident #10 and a co-worker. E-20 stated, "He [Resident #10] wanted [staff member] to do something. The [staff member] started swearing at [Resident #10] and [the staff member] got fired." The verbal interaction between Resident #10 and a staff member, which took place on 12/12/12 according to LSW #1, was not brought to the attention of the LSW or the Administrative staff until the next day, 12/13/12. The Administrator was notified by LSW #1 of the alleged abuse on 12/13/12. The Bureau of Facility Standards did not record any call to the department's hotline and did not record any faxed report of a completed investigation of the incident of alleged abuse on 12/12/12 as required in Informational Letter #2005-1. The facility failed to report the incident between Resident #10 and a staff member to the Bureau of Facility Standards as required by State law and federal regulations.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	F226 DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 10, #16 and #17 were affected by this deficient practice. Based on review of the facility' s abuse policy, review of investigations, review of personnel files, record	

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F 226	Continued From page 20 Based on policy review and staff interview, it was determined the facility failed to develop and operationalize policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property. That failure directly impacted 3 of 17 residents (Residents #10, #16 and #17) involved in significant incidents. This resulted in placing Resident #17 in immediate jeopardy with potential for serious harm or impairment due to ongoing abuse. Additionally, this resulted in the potential for on-going abuse and mistreatment to occur to Residents #10 and #16 without immediate protection and notification, thorough investigations and appropriate corrective action being taken. The findings include: 1. The facility's Resident Abuse/Neglect policy, undated, defined verbal abuse as "any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance to describe residents, regardless of their age, ability to comprehend or disability." Additionally, sexual abuse "includes, but is not limited to, sexual harassment, sexual coercion or sexual assault." a. On 2/14/13 at 12:40 p.m., four investigations from the past year were chosen at random for review. A Report of Investigation, undated, contained an allegation of abuse against LN # 19 to Resident #17 on 8/5/12. The statement from CNA #8, undated, stated "I witnessed a situation between [Resident #17] and [LN #19]. I saw and heard [Resident #17] yelling at someone at the Nurse's station...When I approached the Nurse [sic] station I saw [LN #19] standing outside of the Nurse [sic] station...she was laughing very loud and was taunting and mocking [Resident #17]. [Resident #17] was yelling back at her and called	F 226	review and staff interviews it was determined that the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were immediately reported, residents were immediately protected, allegations were thoroughly investigated and appropriate corrective action was taken. Staff employed at the Idaho State Veterans Home - Lewiston who were involved with the alleged abuse of residents #10, #16 and #17 were placed on administrative leave while thorough investigations were conducted. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All staff have been in-serviced regarding the updated policy and the behavioral expectations of reporting any alleged abuse, neglect or mistreatment of residents. Leadership has been transitioned to an interim staff to ensure the appropriate identification and investigation of alleged complaints of abuse, neglect or mistreatment. Future leadership will be extensively in-serviced regarding the behavioral expectations for reporting abuse allegations to all the appropriate agencies as well as to Division Headquarters staff to ensure that reporting requirements are met. Any identified failures to report abuse according to policy will be address as a performance issue with staff. Residents with behavioral concerns will have a behavior management plan and silent in-services will be used to reeducate the staff on behavior modification techniques. Staff have been in-serviced to the updated behavioral management plans for effective implementation. The Director of Social Services from Boise has conducted resident interviews of approximately 50% of the residents to identify concerns of abuse, neglect or mistreatment. No new issues were identified during this process. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice	

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F 226	Continued From page 21 her a 'f***ing b***ard' and threw an ice bag he had wrapped around his neck at her and saying to [LN #19] "stick it up your a*s" and gave her the middle finger. [LN #19] just laughed at him even louder and told [Resident #17] 'that she doesn't like to do it that way'...There were 2 other [LN]'s at the Nurse's station [LN #6] who was sitting charting and [LN #9]...neither of them interviend [sic] or looked up." On 2/14/13 from 3:05 - 3:30 p.m., CNA #8 was asked about the 8/5/12 incident. CNA #8 stated she reported the incident verbally to the DON on 8/6/12 or 8/7/12. CNA #8 stated the DON requested that it be put in writing, which she completed and gave to the DON between 8/7/12 and 8/9/12. On 2/14/13 from 4:10 - 4:56 p.m., the DON stated she talked with LN #19 before this incident and told her if she needed help redirecting Resident #17, to let her know. The Report of Investigation did not include any information related to LN #6 and LN #9 or the DON. b. The Report of Investigation contained documentation of seven employee interviews conducted by LSW #1, undated and untimed. The interviews documented that employees were aware and reported to management staff, LN #19's ongoing abuse of Resident #17 with no action being taken by the facility, as follows: - Worker #1 stated " ...she's caught [LN #19] cussing at [Resident #17] in the past and had to step in to actually redirect [LN #19]. She notes [LN #19] continues to do things which taunt [Resident #17]...This particular staff member notes they have warned [LN #19] about her actions to no avail." - "Worker #2 noted much of the same	F 226	does not recur. All staff have been in-serviced regarding the updated policy and the behavioral expectations of reporting any alleged abuse, neglect or mistreatment of residents. Leadership has been transitioned to an interim staff to ensure the appropriate identification and investigation of alleged complaints of abuse, neglect or mistreatment. Future leadership will be extensively in-serviced regarding the behavioral expectations for reporting abuse allegations to all the appropriate agencies as well as to Division Headquarters staff to ensure that reporting requirements are met. Any identified failures to report abuse according to policy will be address as a performance issue with staff. Residents with behavioral concerns will have a behavior management plan and silent in-services will be used to reeducate the staff on behavior modification techniques. Staff has been in-serviced to the updated behavioral management plans for effective implementation. Social Service has had their policy manual extensively revised to address the current practice and expected professional practice. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The interventions and in-servicing by the interim staff have created an environment in which abuse allegations are reported by all staff. Future leadership staff will be extensively in-serviced to ensure understanding of the policy and all behavioral expectations included in the policy. Idaho Division of Veterans Services staff will monitor this process on a monthly basis for the next 12 months through review of the reported polices, staff interviews, review of documentation to ensure policies are followed and abuse allegations are reported. 5. Date Corrective action will be completed: April 15,2013	

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F 226	Continued From page 22 above...worker #2 [sic] stated [LN #19] will flirt with [Resident #17] and then tell him to leave her alone when he wants to continue the contact...When asked, worker #2 noted name-calling, the flirting, and the off-hours spent between [Resident #17] and [LN #19] as being very unprofessional." The documentation of Worker #2 ' s interview did not include specific names called, what Worker #2 meant by " flirting " , and it could not be determined what exactly took place during those " off-hours. " - "Worker #3" stated the only thing she had witnessed was the 'Cat & Mouse' game between "[Resident #17] and [LN #19]." The documentation of Worker #3 ' s interview did not include any additional information describing the " cat & mouse " game. - "Worker #4 was relieved to be talking about this issue of [Resident #17] and [LN #19] and noted frustration over past attempts at getting someone to do anything about this. She spoke of this relationship/issue going back at least a year and a half and noted other co-workers trying to tell [LN #19] or warn her of her inappropriate actions with him...She states [LN #19] gets very obnoxious when others try and warn her of her actions and will often yell, cuss, or just make things harder on the aids [sic]. She also stated she and others have said things to management but, still are [sic] no changes in [LN #19]'s behaviors. She notes [LN #19] appears to love the attention and drama she gets from [Resident #17]. She also reportedly jokes in inappropriate and vulgar ways. When asked for an example, she noted [LN #19] and [Resident #17] will speak about sexual things/acts. [LN #17] is said to have been having one of these conversations with [Resident #17] when she left the room saying,	F 226		

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F 226	Continued From page 23 "You couldn't please me." She also spoke of the other extreme where [LN #19] is now threatening to harm [Resident #17] if he doesn't leave her alone. More specifically, [LN #19] was overheard telling [Resident #17] she would break his hand if he didn't get away from her. She's also been heard telling [Resident #17] how he ' disgusts her. ' On another occasion [LN #19] was heard telling [Resident #17] how he ' stinks ' while she was caring for him. Worker #4 is concerned with all the attention being given to [Resident #17] for his behaviors when she finds [LN #19] to be at fault for encouraging the relationship with such inappropriate behavior in the first place." The interview did not contain documentation of which management staff Worker #2 had reported to in the past. - "Worker #5 was very upset over the lack of attention from management regarding this particular issue. They noted the problems with [LN #19] and [Resident #17] have been going on for well over a year and there have been no noticeable changes in [LN #19]'s behavior. Because of this, many staff have simply given up on the idea of management taking notice and have quit reporting. Also noted by worker #5 [sic] were the many times [LN #19] would come to work early just to sit with [Resident #17] in his room. The conversations were noted as being flirtatious and inappropriate but warnings from staff were said to be ignored by [LN #19]...Worker #5 reports if [LN #19] isn't flirting with [Resident #17] she's calling him an 'a*s' or some other name, yelling at him to get away from her even though he's not purposefully seeking her attention, or just taunting him with gestures and looks. These things are said to have often left [Resident #17] crying and feeling confused."	F 226		

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F 226	Continued From page 24 - "Worker #7 was very reluctant to speak with this worker and at one point asked if she and others were going to lose their jobs over this relationship between [Resident #17] and [LN #19]. When asked why anyone would be fired, worker #7 [sic] stated people have been afraid to speak up for fear of retaliation by other nurses in charge or even management who, 'clearly like [LN #19].' When asked what she meant by management, worker #7 [sic] gave the names of [DON] and [RN Manager]...She spoke of the relationship between [Resident #17] and [LN #19] as being wrong and weird. She said it's been totally unprofessional from one extreme to the other. She explained that [LN #19] would spend hours sitting in [Resident #17]s [sic] room with him after her shift was over. They'd laugh and talk about getting married and having children together. She said they'd do this in the common area as well as if [LN #19] needed other people to know [Resident #17] was in love with her. She then noted how [LN #19] would be totally opposite and just get mean with [Resident #17] to the point he would cry." On 2/15/13 from 9:18 - 9:38 a.m., the RN Manager stated her staff would casually tell her that the relationship between Resident #17 and LN #19 was inappropriate, but no one ever came to her directly with " grave concerns. " On 2/14/13 from 4:10 - 4:56 p.m., the DON stated talked with LN #19 before and told her if she needed help redirecting Resident #17, to let her know. On 2/14/13 from 4:10 - 4:56 p.m., the Administrator stated she was unaware of the allegation against LN #19 until the statement written by CNA #8 was placed on her desk on 8/15/12.	F 226		

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c. The Report of Investigation did not document how Resident #17 was protected from ongoing abuse. Additionally, during the course of the survey, staff were interviewed about LN #19 with the following results:
- Employee #14 stated LN #19's family member was a resident at the facility and LN #19 still visited him. She said that when LN #19 visited, Resident #17 cried and got very upset. Employee #14 requested that arrangements be made for LN #19 to visit her family member in a private area, but nothing was done with her request.
- Employee #20 stated at one point, Resident #17 was put on suicide watch due to the interactions with LN #19. She stated since LN #19's employment ended, LN #19 had been back to the facility to visit her family member and continued to tease Resident #17 in a sexual nature. Employee #20 said she reported multiple times to the DON that LN #19 was responsible for the inappropriate relationship, but nothing was done.
- Employee #13 stated LN #19 had visited the facility to visit her family member one or two times since her employment with the facility ended, and the visits upset Resident #17.
- LSW #1 stated during an interview on 2/14/13 from 6:15 - 6:40 p.m., he had not witnessed firsthand LN #19 ' s post-employment visits, but had received reports that Resident #17 was upset for quite some time after LN #19 visited the facility. LSW #1 stated LN #19 should have guidelines or supervision in place to visit, but as far as he knew, she did not.
- LSW #2 was interviewed on 2/15/13 from 9:39 - 10:57 a.m. LSW #2 stated she had heard that Resident #17 was tearful during LN #19 ' s continued visits to the facility. LSW #2 stated when LN #19 was not visiting; Resident #17 was

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F 226	Continued From page 26 in good spirits. LSW #2 stated she was unaware of any guidelines for LN #19 to make arrangements to visit the facility and stated she herself, did not have any responsibilities if LN #19 visited (such as notifying the Administrator, escorting LN #19, etc.). - The RN Manager stated, during an interview on 2/15/13 from 9:18 - 9:38 a.m., her staff would casually tell her that the relationship between Resident #17 and LN #19 was inappropriate, but no one ever came to her directly with " grave concerns. " - The Administrator stated, during an interview on 2/14/13 from 4:10 - 4:56 p.m., in the past she heard staff occasionally say, " [Resident #17] ' s going to see [LN #19]. " however, she was unaware of the extent of the situation until the Report of Investigation was completed in August 2012. Further, the Administrator said she was responsible for placing employees on administrative leave through communication with Human Resources and allowing LN #19 to continue working during the course of the investigation was her decision. The Administrator failed to protect Resident #17 from ongoing abuse. Upon conclusion of the investigation, the Administrator terminated LN #19 on 9/6/12. d. The Report of Investigation documented the investigation was not initiated until 8/21/12. No explanation for the time delay between the 8/5/12 incident until the initiation of the investigation could be found. e. The Report of Investigation did not include documentation that Resident #17, the DON and the RN Manager were interviewed. f. The allegation of abuse by LN #19 was not reported to the Bureau of Facility Standards in Informational Letter #2005-1.	F 226		

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F 226	Continued From page 27 g. The Report of Investigation did not include evidence that corrective action was taken with all employees including management staff who were aware of LN#19's ongoing abuse to Resident #17. Finally, employees of the facility including management staff (who were aware of LN#19's ongoing abuse to Resident #17 during her employment) were also aware of LN #19's current contact with Resident #17 during her visits. The survey team read, and provided in writing, the following statement on 2/15/13 at 8:45 a.m.: " During an Idaho State recertification survey, initiated 2/11/13 a deficient practice was identified at 483.13(c)(2), 483.13(c)(3), 483.13(c)(4) 483.13(c). This failed practice resulted in serious harm constituting immediate jeopardy. The Idaho State survey team determined the facility failed to protect a resident from further abuse when they allowed a facility staff member, who was terminated for the abuse, enter the facility without structured guidelines and/or supervision. The staff member was allowed to visit a family member and former co-workers without protecting the resident from abuse. In addition, the facility failed to investigate, thoroughly and immediately, all allegations of abuse, protect the resident during the investigation, and report the allegation and the investigation to the appropriate agencies as required. These failed practices were brought to the attention of the facility Administrator and Director of Nursing on 2/15/13 at 0845. The facility was provided specific details of these failures. Idaho State Veteran ' s Home - Lewiston should begin immediate removal of the risk to individuals and immediately implement corrective measures	F 226		

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F 226	Continued From page 28 to prevent repeat jeopardy situations. " The document was signed by the survey team, the Administrator, and the DON. NOTE: An acceptable Plan of Correction was submitted on 2/15/13 at 2:15 p.m. and the immediate jeopardy was abated. 2. The facility's Administrator was asked for the policy related to abuse and neglect on 2/14/13 at approximately 11:20 a.m. On 2/14/13 at 2:00 p.m., the facility's Administrator provided the survey team with a documented titled Resident Abuse/Neglect. When asked during a telephone interview on 2/19/13 at approximately 3:00 p.m., the Administrator stated the Resident Abuse/Neglect policy was put in place sometime in November 2011. The policy was reviewed and was not sufficient to ensure residents were not subjected to mistreatment, neglect, abuse, and misappropriation of their property, as follows: a. Under the section titled Policy/Purpose, it stated residents had a right to be free from corporal punishment. Corporal punishment was not defined. b. Under the section titled Definitions, it listed Sexual Abuse, Physical Abuse, and Mental Abuse. However, definitions for sexual, physical, and mental abuse were not included. c. Injuries of an unknown origin, resident-to-resident abuse, and self-injurious behavior were not included under the section titled Definitions. d. Under the section titled Implementation, it	F 226		

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stated "Any person who has knowledge of any act of abuse, neglect, or misappropriation of resident property shall report such information to their immediate supervisor ...who in turn, shall immediately report such information to the home administrator."

As stated, immediate intervention and protection of the resident was not provided. Additionally, the policy did not include information related to immediately suspending the alleged staff and timely notification of family members and/or legal representatives.

e. Under the section titled Implementation, the policy stated "Criminal history checks shall be completed on all staff employed at [the facility]."

The policy did not contain information related to when and where criminal history checks were to be completed, fingerprint requirements, supervision requirements until criminal history checks were completed, and procedures to be taken if a criminal history check came back with offenses that would prohibit employment. Additionally, the policy did not include information related to obtaining information from previous employers and/or current employers.

f. Under the section titled Implementation, it stated "All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state law."

The policy did not include timelines for conducting an investigation and what was to be included in

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an investigation (i.e., witness statements, resident interview, etc.). Additionally, there was no information as to what to do if the alleged staff was the Administrator.

g. Under the section titled Implementation, it stated "The facility will ensure that further potential abuse will not occur while the investigation is in progress. Any employee under investigation for violation of this policy shall be suspended from employment ..."

The policy did not include information on how the facility would ensure potential abuse did not occur and there were no timeframes associated with suspending an employee.

h. Under the section titled Implementation, it stated "The Administrator or his designee shall report to the state licensing authority ..." The policy did not include information on who was responsible for reporting if the alleged staff was the Administrator or his designee.

The policy stated "These shall be reported to the appropriate officials within the time frames established by the Bureau of Facility Standards." The policy did not include the specific timeframes.

The policy stated "If a law violation has occurred, the report of such violation shall be made immediately ..." The policy did not include information as was constituted a law violation.

i. Under the section titled Implementation, it stated "based on the results of the facility investigation, appropriate disciplinary action will

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F 226	Continued From page 31 be taken, up to and including termination of an employee." The policy did not include information related to corrective action being taken to prevent the reoccurrence of abuse. j. Under the section titled Investigating and Reporting, it stated "The Administrator of [the facility], or the Acting Administrator in his absence, shall be responsible for directing the investigation and complying with all reporting requirements." The policy did not include information as to what to do if the alleged staff was the Administrator and/or the Acting Administrator. Additionally, there was no specific timeframes associated with "complying with all reporting requirements." k. Under the section titled Training, it stated "The content of this training shall include identifying appropriate interventions in dealing with aggressive and/or catastrophic reactions of residents ..." However, under the section titled Prevention, it stated "Careful attention will be give [sic] to all residents during the assessment and care planning processes for residents who may have special needs because of behaviors such as aggressiveness, catastrophic reactions, self-injury, nonverbal communication, or those who require heavy or total nursing care. These residents are to be viewed as especially vulnerable and deserving on ongoing protection." The policy did not include information related to	F 226		

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F 226	Continued From page 32 training staff on residents' special needs including self-injury, nonverbal communication, or those who require heavy or total nursing care to ensure ongoing protection was provided. l. Under the section titled Identification, it stated "All events which warrant reporting via the facility Incident/Accident reporting system shall be tracked so as to be able to identify suspicious events, occurrences, patterns or trends that may constitute abuse or neglect. The facility administration shall be responsible for monitoring this tracking system and shall determine when a preponderance of the data indicates that an investigation is necessary." The policy did not contain sufficient information related to how often data would be analyzed to ensure residents were protected from harm and immediate action was taken. m. Under the section titled Evaluation, it stated "All suspected cases of abuse, neglect and misappropriation of resident property will be investigated and reported as required by this procedure and State Law." As identified above, immediate protection to the resident would not be provided, there was no information related to the immediate suspension of alleged staff, and notification of family members and/or legal representatives was not included in the policy. n. Under the section titled Evaluation, it stated "The administrative or nurse charge/manager immediately notifies ...and ...immediately investigates the alleged incident."	F 226		

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The policy did not include information on what to do if the alleged staff was the administrative or nurse charge/manager.

o. Under the section titled Evaluation, it listed four steps to be utilized to ensure a thorough investigation was conducted. The last two steps were as follows:

- "If a staff member is implicated in the incident, the person will be instructed to discuss [sic] situation with the Administrator or the Director of Nursing." As stated, it was not clear who (the implicated staff or the investigator) was to talk with the Administrator or Director of Nursing.

- "Continued facility investigation may occur, as needed, over the next 24-48 hours." As stated, completing an investigation was a choice and would not be sufficient to ensure a thorough investigation was completed.

Additionally, the policy did not include information related to interviewing the resident(s) involved in the incident.

3. An Incident Investigation, undated, summarized an investigation conducted from 8/13/12 - 8/15/12 regarding an allegation of abuse on Resident #16, during a shower on 8/1/12 by LN #19 and CNA #20. Resident #16 ' s Resident Facesheet, undated, documented a 91 year old male whose diagnoses included Alzheimer ' s disease.
a. LN #19 was placed on administrative leave 8/14/12 for protection of the residents, however, CNA #20 was not.

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F 226	Continued From page 34 When asked during an interview on 2/19/13 from 2:50 - 3:12 p.m., the Administrator stated CNA #20 was not placed on administrative leave because once statements clarifying the allegation were received, the focus was placed on LN #19. b. CNA #3 witnessed the shower on 8/1/12 and reported the incident to LN #4 on 8/12/13. LN #4 then reported the incident to the Administrator on 8/13/13. However, the Incident Investigation did not contain documentation that CNA #3 or LN #4 were retrained on the abuse policy, including immediate protection of residents or immediate reporting. When asked, the Administrator stated during an interview on 2/19/13 from 2:50 - 3:12 p.m. she carried a facility phone 24 hours a day, seven days a week to facilitate immediate reporting. She stated she would check personnel files for documentation of the abuse policy, however, the facility failed to provide any additional documentation. 4. Resident #10 was admitted to the facility on 6/10/09 with multiple diagnoses including dementia and depression. The resident's most recent quarterly MDS assessment, dated 10/15/12, coded: * Understood and usually understands * BIMS of 9 indicating moderately impaired cognitive skills for daily decision making * No signs or symptoms of delirium present * Physical behavioral symptoms directed toward others occurred 1 to 3 days during the 7 day look back period * Verbal behavioral symptoms directed toward others occurred 4 to 6 days during the 7 day look back period * Mood score for depression was zero indicating no signs or symptoms of depression during the	F 226		

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F 226	Continued From page 35 14 day look back period Resident #10's Physician Orders for 2/2013 documented the resident received Depakote 750 milligrams by mouth 3 times a day for "1) Verbal and physical aggression 2) Irritability and angry outbursts" and "3) Refusing cares, bathing & treatments..." Resident #10 ' s Plan of Care documented the problem, dated 6/18/09, " AIA [unknown]. " interventions included, " ...Provide opportunity for communication/socialization during each contact. " Under the problem, " Ineffective Individual coping, " dated 6/10/09, interventions included, " ...1:1, diversional activities ...validation, redirection. " On 12/13/12, a Social Services Progress Notes entry (untimed), recorded by LSW #1, documented, "Staff have shared info[rmation] about [Resident #10] having had a verbal altercation w/staff [with staff] during dinner last night [12/12/12]. He separately threatened physical harm and the staff responded inappropriately, but then walked away. ...Social Services will speak with & remind him of not only the consequences of his action but his responsibility to respect staff and other residents." A second untimed note, recorded on 12/13/12 by LSW #1, documented, "Spoke w/[Administrator's name] who agreed [Resident #10] has now escalated his verbal abuse to physical threats [with] staff. With 2 staff having reacted as shared their inability to cont[inue] working or under this abuse, it may be time to look at transferring [Resident #10] to another facility. ..." During an interview with Employee #20 (E-20), the employee was asked about abuse, in general, in the facility. E-20 said that sometime recently, at	F 226		

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F 226	Continued From page 36 least during the last year, E-20 knew about verbal abuse between Resident #10 and a co-worker. E-20 stated, "He [Resident #10] wanted [staff member] to do something. The [staff member] started swearing at [Resident #10] and [the staff member] got fired." The verbal interaction between Resident #10 and a staff member, which took place on 12/12/12 according to LSW #1, was not brought to the attention of the LSW or the Administrative staff until the next day, 12/13/12. The Administrator was notified by LSW #1 of the alleged abuse on 12/13/12. The Bureau of Facility Standards did not record any call to the department's hotline and did not record any faxed report of a completed investigation of the incident of alleged abuse on 12/12/12 as required in Informational Letter #2005-1. The facility failed to report the incident between Resident #10 and a staff member to the Bureau of Facility Standards as required by State law and federal regulations. The facility failed to develop and operationalize policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 241	F 241 DIGNITY AND RESPECT OF INDIVIDUALITY This requirement was not met as evidenced by the determination that the facility failed to ensure resident's dignity when staff wiped resident's mouths with the residents clothing protectors while dining and wiped resident's mouths with the blanket covering their laps. In addition staff moved a residents belonging without the resident's permission. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	

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F 241	Continued From page 37 determined the facility failed to enhance residents' dignity when staff wiped residents' mouths with the residents' clothing protectors while dining and wiped residents' mouths with the blanket covering their laps. This was true for 5 random residents (#s 18, 22, 23, 24, & 25). In addition, staff moved a resident's belongings without the resident's permission. This was true for 1 of 9 sampled residents (#8). These failed practices had the potential to negatively affect the residents' self-esteem. Findings included: 1. On 2/12/13 at 7:30 am, CNA #8 was observed assisting Resident #23 to dine. The resident had a clothing protector on and had a cloth napkin on the table next to his place setting. During the meal, CNA #8 used the clothing protector to wipe the resident's mouth instead of the napkin. 2. On 2/12/13 at 8:50 am, LN #14 approached Resident #18 in the television area next to the entrance to the East hallway to administer the resident's medications. The resident had secretions coming from his mouth and dripping onto his chin. LN #14 took the end of the blanket that was covering the resident's lap, wiped the secretions with the blanket and placed the end of the blanket back on the resident. LN #14 then administered the medications, but did not replace the soiled blanket on the resident's lap. 3. On 2/12/13 at 12:45 pm, LN #15 was observed assisting Resident #22 to dine. The resident had a clothing protector on and had a cloth napkin on the table next to his place setting. During the meal, LN #15 used the clothing protector to wipe the resident's mouth instead of the napkin.	F 241	During the February 27, 2013 2:15pm All Staff meeting - This F tag was discussed with respect to residents #18, 22, 23, 24, &25 and a verbal in-service was presented on resident dignity and respect. All facility staff were educated to utilize appropriate cleaning material to assist a resident with cleaning their face and to use a napkin or washcloth to clean instead of using the residents blankets or the clothing protectors. Social Worker has met with Resident #8 on 2/15/13 and again on 3/15/13 regarding his belongings being moved without his permission. Social worker identified that Resident #8 has a lot of belongings and likes to keep his belongings stacked up in his room and does not want staff to rearrange his belongings. During the meeting with the resident #8 it was determined that when this residents belongings begin to infringe on his roommates space or become a safety issue then staff will meet with this resident and identify concerns and work with this resident to manage his belongings. Resident #8 plan of care was updated and nursing staff were in-serviced to this plan. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility have the potential of being affected by this deficient practice. All staff was verbally in-serviced on 3/7/13 at All Staff meeting about these resident dignity issues - with relationship to appropriately providing facial hygiene. Additionally all licensed nursing staff were in-serviced regarding cleaning resident faces appropriately and not using blankets or clothing protectors. Social Services reviewed all residents residing in the facility and determined one other resident to have a cluttered room. Social Services met with that resident on 3/15/13, discussed	

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F 241	Continued From page 38 4. On 2/12/13 at 1:00 pm, CNA #8 was observed assisting Resident #24 to dine. The resident had a clothing protector on and had a cloth napkin on the table next to his place setting. During the meal, CNA #8 used the clothing protector to wipe the resident's mouth instead of the napkin. 5. On 2/13/13 at 8:40 am, Resident #25 was observed sitting in her wheelchair in the West hallway near the medication cart. CNA #17 was observed to reach for the right hand corner of the blanket covering the resident's right shoulder, wiped the resident's mouth with the blanket, and placed the corner of the soiled blanket back on the resident's right shoulder. CNA #17 did not replace the resident's blanket. On 2/14/13 at 5:40 pm, the Administrator and DON were informed of the observations. The DON shook her head, but provided no other information or documentation that resolved the concern. 6. Resident #8 was originally admitted to the facility on 10/19/10 and re-admitted on 1/11/13, with diagnoses including dementia and hip joint replacement. Resident #8's Change of Condition MDS, dated 1/17/13, coded: -BIMS of 15, indicating Resident #17 is cognitively intact -Very important to have a place to lock things and keep them safe -Very important to take care of own belongings -Requires supervision to limited assistance for most ADLs -Able to walk in room with set-up and supervision	F 241	with the resident a plan for resident and staff to best organize his belongings, this conversation was documented in the Social Services notes, resident plan of care updated and nursing staff was in-serviced. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All nursing staff were in-serviced regarding resident dignity and appropriate cleaning of resident faces. As well as in the dining rooms each resident has a cloth napkin available. Face and hand washing supplies have been made available in both dining areas for appropriate hygiene. All nursing staff were in-serviced regarding the best way to assist a resident with managing their personal belongings (refer the issue to Social Services who will meet with the resident and develop a plan with the resident, update the plan of care and in-service the staff to the plan.) CQI Dining Environment has been modified to include item to audit residents and how their hygiene in the dining room is completed. CQI Social Services has been modified to include items to audit residents and how issues regarding managing their personal belongings is addressed. The ISVH-L Medication Administration skills assessment has been modified to include monitor for how the nurse manages facial hygiene during the medication pass. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Dining Environment and Social Services These CQI will be done q week x 4 weeks, then q month x 3 months, then every three months. These CQI will start March 25, 2013 Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration Skills	

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F 241	Continued From page 39 On 2/12/13 at 8:45 AM, during a Resident Interview on the subject of privacy, Resident #8 stated, "There's only one thing. When I was at [name of hospital] in January for my hip surgery, someone, and I don't know who, straightened up and re-arranged my stuff. That makes it hard because my short-term memory doesn't work, and now I can't find anything. They won't let me keep my books and magazines in bags on the floor, and I understand that. It's a fire hazard. But if I could have seen where they were putting stuff, it would have helped me later. I want to do things for myself." Resident #8 then escorted the surveyor to his room, and pointed out areas where he had things stored, and where they had been moved while he was in the hospital. He stated, "I still can't remember where everything is now." On 2/13/13 at 1:30 PM, the DON and Administrator were asked about Resident #8's belongings. The Administrator stated the facility discarded several food items while the resident was in the hospital, then took the opportunity to re-arrange his things. The Administrator stated this was not done to annoy the resident, but to straighten his belongings. The Administrator was asked if there was a reason this was not done while the resident was present, with his input and permission. The Administrator stated, "I guess we didn't think of doing it that way." No further information was offered to resolve this concern.	F 241	Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor nursing practice are identified then that nurse will receive individual in-service training based on need and re-evaluated. 5. Date Corrective action will be completed: April 15, 2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE- REVISE CAREPLAN This requirement was not met as evidenced by the determination that the facility failed to ensure a	

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F 280	Continued From page 40 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure a comprehensive care plan was revised after each assessment for 1 of 9 residents (Resident #9) whose care plan and assessments were reviewed. This resulted in a resident continuing to wear a Wander Guard bracelet after it was determined it was not necessary. The findings include: 1. Resident #9 was an 86 year old male diagnosed with dementia. He was admitted to the facility on 2/8/11. During the initial tour on 2/11/13 starting at 1:45	F 280	comprehensive care plan was revised after each assessment for 1 of 9 residents (#9) whose care plan and assessments were reviewed. This resulted in a resident continuing to wear a Wander Guard bracelet after it was determined it was not necessary. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #9 has had the Wander Guard bracelet removed and his plan of care has been updated. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who reside in the facility and wear a Wander Guard bracelet have the potential to be affected by this deficient practice. All residents who currently wear a Wander Guard bracelet were identified; each resident was reviewed and placed on 72 hours of alert charting to aid in the evaluation for need of the Wander Guard. Those residents who were determined to no longer require a Wander Guard bracelet had the bracelet removed and their plan of care updated. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. A current list of residents who wear a Wander Guard Bracelet has been posted at the Nurses Station Social Services will evaluate residents who utilize a wander guard bracelet for wandering on a monthly basis. If Social Services identifies that a resident does not have any documentation to support the need for a Wander Guard bracelet, then that resident will be placed on Alert Charting for 72 hours. After the 72 hours of documentation is complete then the resident will then be re-evaluated for the need to discontinue the Wander Guard device.	

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F 280	Continued From page 41 p.m., an alarm was heard by the surveyor. When asked about the alarm, the RN Manager who was present, stated it was a loiter alarm. The RN Manager stated alarms were on all exit doors and was activated by residents who wore Wander Guard bracelets who were in close proximity of the exits. When asked, the RN Manager stated she was not sure who wore bracelets but could find out. The survey team received a document, titled Residents with a Wander Guard. Resident #9 was identified on the list as having a Wander Guard bracelet. Resident #9's Plan of Care, dated 12/12/12, stated "Wanderguard [sic] in place d/t [Resident #9's] tendancy [sic] to wander, exit seeking at times." However, Resident #9's quarterly MDS, dated 9/24/12, and his annual MDS, dated 12/10/12, documented he did not exhibit wandering behavior (E0900 was coded zero). When asked about the discrepancy between Resident #9's MDS data and his Plan of Care, the Administrator stated during a telephone interview on 2/19/13 at 2:50 p.m., Resident #9 did not need a Wander Guard. The Administrator stated Resident #9's Plan of Care was not accurate and it should have been revised. The facility failed to ensure Resident #9's Plan of Care was revised when it was determined he did not need a Wander Guard bracelet.	F 280	If it is determined that the resident does not require the Wander Guard device then the bracelet will be removed from the resident and the resident's plan of care will be updated. CQI Social Services has been modified to include monthly monitoring of the Wander Guard residents. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Social Services This CQI will be done q week x 4 weeks, then q month x 3 months, then every three months. The CQI will start March 25, 2013 5. Date Corrective action will be completed: April 15, 2013	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	

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F 281	Continued From page 42 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Nursing Procedure Manual, it was determined the facility: 1. Failed to have Resident #21 rinse her mouth with water and spit out the water after inhalation of a steroid medication. This failed practice had the potential to result in oral fungal infections. 2. Signed medication as administered before the medications were administered to Resident #18. This failed practice had the potential to result in medication errors. 3. Left medications unlocked and unattended: blister packages containing medications were left on the top of medication carts, a medication cart and a treatment cart, which were able to be locked, were left unlocked. This failed practice had the potential for residents and/or visitors to access medications that were not prescribed for them. Findings included: 1. Nursing 2013 Drug Handbook, 33rd Edition, 2013, stated on page 185 concerning the medication QVAR (beclomethasone...inhalation), "...Advise patient to prevent oral fungal infections by gargling or rinsing his mouth with water after each use. Caution him not to swallow the water." On 2/13/13 at 8:50 am, the Administrator stated the facility did not have a policy/procedure for administering drugs by inhalation. She handed	F 281	This requirement was not met as evidenced by the determination that the facility failed to A. Have resident #21 rinse her mouth with water and spit out the water after inhalation of a steroid medication. This failed practice had the potential to result in oral fungal infection. B. Signed medication as administered before the medications were administered to resident #18. This failed practice had the potential to result in the medication errors C. Left medications unlocked and unattended. This failed practice had the potential for residents and /or visitors to access medications that were not prescribed for them. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A. The facility put into place a procedure for Administration of Metered Dose Inhalers on 2/13/13. B. The licensed nursing staff has been in-serviced on how to properly administer and document administration of resident medication. C. The licensed nursing staff has been in-serviced on securing resident medication. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. A. The facility put into place a procedure for Administration of Metered Dose Inhalers on 2/13/13. B. The licensed nursing staff has been in-serviced on how to properly administer and document administration of resident medication. C. The licensed nursing staff has been in-serviced on securing resident medication.	

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F 281	Continued From page 43 the survey team a policy called, "Administration of Metered Dose Inhalers," dated 2/13/13, which she described as a "new" policy. The policy documented, "...10. When using a steroid MDI [metered dose inhaler]...instruct resident to gargle or rinse their mouth with water and spit to help inhibit fungal growth. Caution resident not to swallow the water." On 2/12/13, LN #15 was observed to administer QVAR, 1 puff from an inhaler at 9:48 am and a second puff at 9:52 am to Resident #21. LN #15 did not have the resident rinse her mouth with water and spit out the water. On 2/14/13 at 10:10 am, LN #15 was interviewed regarding the above observation. He stated he did not have the resident rinse her mouth and spit. He said he read the new policy regarding this issue. Pharmacist #12 was asked about the inhaler issue. He said that he has not had any inservices on administration of inhalers, but will offer some instructions in the future. 2. Informational Letter #97-3, dated April 16, 1997:The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to	F 281	3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Medication Administration and Medication Orders procedure has been revised, this procedure includes the facility procedure for Medication and Treatment Carts and that these carts are to be kept locked when not in use; the Administration of Metered Dose inhalers (including steroid inhaler), as well as a new procedure for medication administration documentation that directs the nurse to make a dot or small check in the box when the medication is removed from the blister pack/container and then the medication is to be signed off/initialed after given. All licensed nursing staff will be in-serviced to this procedure. Additionally a more detailed in-service has been given to all the licensed nursing staff regarding the "dot " procedure, these in-services also include detailed information on how to properly administer a MDI. A flow chart for administering multiple inhaled medications has been developed in conjunction with the pharmacist and all nursing staff are being in-serviced to this flow chart. This flow chart will be placed at the front of each MAR on each medication cart. All residents who have a prescription for MDI have been identified and specific perimeters are being placed with these MDI orders to ensure that the MDI is given per the proper perimeters such as sequence of inhalers, time between puffs, and rinsing out mouth with water and spitting out the water in the case of a steroid inhaler All licensed nursing staff will be evaluated using the ISVH-L Medication Administration Skills Assessment. This assessment evaluates the nurse in multiple areas during medication administration including but not limited to locking the medication cart when not in use, using the dot system	

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F 281	Continued From page 44 do." During a medication pass on 2/12/13, LN #14 prepared 9 medications for Resident #18 by placing the medications in medicine cups. Before he gave the medication, LN #14 signed each medication as given by initialing the MAR for the appropriate date and time for each of 9 medications. After the LN administered the medication, he was asked about signing the medications as given before he actually gave the medication to the resident. He stated, "I know that [medications should not be signed before given]." 3. Potter & Perry, 7th Edition, 2009, stated on page 703, "Special medications rooms, portable locked carts...are examples of storage areas used. Make sure that all medication are in locked containers...or are under constant surveillance." a. On 2/12/13 at 8:50 am during the medication pass observation, LN #14 prepared 9 medications for administration. He stated he needed to check on the whereabouts of 2 additional medications that were not in the medication cart and scheduled to be administered at 9:00 am. LN #14 left the blister packages/packets containing the monthly supply of the 9 medications on top of the cart unlocked and unattended in the East Hallway entrance that was easily accessible to residents, family, visitors or other staff. On 2/12/13 at 9:10 am during the medication pass observation, LN #7 prepared 4 medications for administration. LN #7 left the blister packages containing the monthly supply of these 4 medications on top of the West medication cart unlocked and unattended in the hallway while she	F 281	when administering medication, and proper administration of inhaled medication. If areas of poor technique are identified then that nurse will receive individual in-service based on need and re-evaluated. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration Skills Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor technique are identified then that nurse will receive individual in-service training based on need and re-evaluated. 5. Date Corrective action will be completed: April 15, 2013	

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F 281	Continued From page 45 washed her hands in another room. The medications were easily accessible to residents, family, visitors or other staff. On 2/14/13 at 10:45 am, LN #7 was asked about leaving the medications unlocked and unattended. She said, "I thought you [the surveyor] were responsible for the medications." b. On 2/12/13 at 10:20 am, the 4 drawers in the East medication cart were observed to be unlocked and unattended while the cart was positioned outside a resident room accessible to residents, visitors, family and other staff. The drawers contained blister packages/packets of residents' prescription medication, over-the-counter medication, insulin, eye drops and inhaled medications. LN #14 was asked about the unlocked/unattended medication cart. He stated he was answering a resident call light and acknowledged the drawers were not locked and the medication was "not in direct sight." He locked the cart. On 2/13/13 at 10:10 am, the drawers of the East treatment cart were observed to be unlocked and unattended while the cart was positioned at the entry to the East hallway accessible to residents, visitors, family and other staff. The cart contained a variety of topical medications. LN #14 returned to the cart after exiting a resident's room, noticed the treatment cart was unlocked and, then, locked the treatment cart. On 2/13/13 at 2:15 pm until 2:25 pm, the East medication cart's second drawer was observed to be open. The drawer contained resident's prescription medications. During the time the cart was unlocked and unattended, 3 residents and 4 CNAs walked by the cart. At 2:25 pm, LN #15 walked by the cart, noticed the second drawer was open, and pushed the drawer in and locked	F 281		

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F 281	Continued From page 46 the cart. On 2/12/13 at 4:10 pm, the Administrator and DON were informed of all of the medication issues. On 2/13/13 at 3:20 pm, the Administrator and DON were informed of the unlocked medication and treatment carts. The DON stated the LNs had informed her of the unlocked carts and unattended medications and she provided counseling to the LNs regarding these issues.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on a complaint received from the public, observation, interview, and record review, it was determined the facility did not ensure residents received interventions for pain control, bowel care, or aspiration issues per their plan of care and physician's orders. This was true for 3 of 14 residents (Resident #'s 6, 9 and 14) sampled for pain, bowel care, and aspiration issues. This deficient practice had the potential to cause more than minimal harm when residents did not receive interventions as care planned for pain control, were at risk of developing fecal impaction, or were at risk for aspiration pneumonia. Findings included:	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING This requirement was not met as evidenced by the determination that the facility failed to ensure residents received interventions for pain control, bowel care, or aspiration issues per their plan of care and physician' s orders. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 6, 9 and 14 were negatively impacted by this practice. Resident #6 was positioned improperly and he has a trough attachment ordered for his wheelchair to aid in proper positioning. The use of device also reduces the resident' s pain. Staff have been in-serviced on proper positioning for this resident while waiting for his positioning device to arrive. Resident # 9 was not managed to ensure proper bowel protocols were used. The bowel and bladder management program has been completely revised to ensure a more effective monitoring program. Daily evaluations of residents have shown that all residents have been monitored for bowel issues and properly medicated per policy to ensure that no resident has gone more than three days without a bowel movement or interventions initiated with documented results. Resident' s rights to refuse will be honored with	

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F 309	Continued From page 47 1. Resident #6 was admitted to the facility on 9/9/2011 with diagnoses including CVA, hemiplegia, dementia, and right shoulder frozen with rotator cuff tear. Resident #6's Quarterly MDS dated 1/22/13 coded: -BIMS of 3, indicating severely impaired cognitive skills -No rejection of care -Extensive assistance of 2 persons for ADLs Resident #6's care plan, dated 1/23/13, documented: -Problem area: Potential for alteration in comfort r/t hx CVA right sided hemiplegia, hx of generalized pain, hx of right humerus fracture. Right rotator cuff syndrome. -Goal: [Resident #6] will report pain less than 3/10 on a daily basis through next review. -Approaches included: * [Resident #6] has an arm support with sheepskin to the right side of his wc to help him maintain his right arm in a comfortable position. [Resident #6] prefers not to have his arm on support at times. *Provide frequent position changes NOTE: There was no direction in Resident #6's care plan directing staff to assist the resident to re-position his arm. There was no documentation regarding education or interventions to encourage Resident #6 to position his arm to reduce his pain. There was no indication as to how frequently his position should be changed, or in what way his position should be changed to increase his comfort.	F 309	proper education of the risks involved. Resident # 14 is no longer a resident at this facility so no corrective actions could be implemented on their behalf; however the facility has identified new products to be used as nutritional supplements for residents requiring nectar thick liquids. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential to be negatively impacted by these deficient practices. Residents with disease process that negatively impact body positioning will be assessed and the use of PT/OT evaluation for proper body alignment and supportive devices will be utilized as appropriate. The implementation of the new bowel program will identify residents that are currently not meeting our bowel care policy and procedure. This program will be monitored weekly X 4 weeks, then biweekly X 4 weeks, then monthly thereafter. The facility has not identified liquid nutritional supplement that meet the requirements for nectar thick liquids. The Dietician and the Food Service Manager have identified those residents requiring nectar thick liquids and nutritional supplements and converted the resident to Ensure pudding in an amount equal to the nutritional requirements provided by the non-nectar thick liquids. Resident resistance to this practice is anticipated and we are continuing to investigate liquid supplements that will meet the nectar thick requirements and are additionally requesting ST evaluations for the safe consumption of liquid dietary supplements. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All new admissions will be assessed for disease conditions that would affect positioning during the Nursing	

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F 309	Continued From page 48 Resident #6's Physician's Orders (recaps) for February 2012 included: -hydrocodone 5/325 1 tablet every 4-6 hours as needed for pain -hydrocodone 5/325 2 tablets every 4-6 hours as needed for pain Resident #6's MAR for February 2013 documented 2 tablets of hydrocodone 5/325 given on 20 occasions, at least once daily, for pain in the right arm or shoulder. On one of those occasions, Resident #6 rated his pain 3/10, on one occasion 6/10, on 2 occasions 7/10, on 8 occasions 8/10, on 7 occasions 9/10, and on one occasions stated his pain was, "bad." There were no documented instances of Resident #6 receiving only one tablet of hydrocodone. On 2/11/12 at 3:45 PM, Resident #6 was observed to be sitting in this wheelchair on the west side of the nurse's station. His head was down and his eyes were closed. He had a ½ lap tray attached to the right arm of his wheelchair with sheepskin loosely attached. He was leaning to his right, with his right arm positioned between the ½ lap tray and his body. His right hand was curled loosely into a fist shape and tucked under his left arm. The sheepskin covering the ½ lap tray was askew, so the portion large enough to cover the tray was partially in Resident #6's lap and underneath his right elbow. The DON was standing approximately 5 feet from Resident #6, facing him. The DON did not offer or attempt to reposition the resident. Resident #6 was observed in the same position in his wheelchair on the following occasions: 2/12/13 between 7:20 and 8:25 AM	F 309	admission/MDS assessments will receive a PT/OT evaluation for proper positioning. Recommendations will be provided to the restorative nurse for implementation and care planning as needed. Bowel care program will be an ongoing monitor for compliance with new bowel program. CQI Elimination has been modified to evaluate the revised bowel program. Following the ST evaluations liquid dietary orders will be consistent with recommendations. Dietician and Food Service Manager will continue to try to identify nectar thick supplements that the residents prefer. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Admission will be monitored by the RN Manager to ensure that proper evaluations, assessments and care plan activities are implemented for proper positioning. The Idaho Division of Veterans Services QI Director will do a double check monthly for issue identification. Residents will have a documented BM at least every three days or documentation to support interventions implemented by staff and if the resident refuses interventions then resident education of risks is documented. Continued refusal of Bowel interventions will be communicated to the resident' s physician for follow up. All residents on nectar thick liquids will be monitored for signs and symptoms of aspiration following the use of either Ensure Pudding or if appropriate consumption of liquid dietary supplements. Treatment records will reflect the documentation of no S/Sx of aspiration following consumption of nutrition supplements. The Administrator will monitor the CQI Elimination This CQI' s will be done q two weeks x 1 month, then q month x 3 months, then every three months x 6 months, then biannually.	

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F 309	Continued From page 49 2/12/13 between 12:50 PM and 2:05 2/13/13 at 1:15 PM No staff was observed to approach Resident #6 to offer or assist with re-positioning his arm during these times. On 2/13/13 at 1:30 PM, the Administrator and DON were asked about Resident #6's arm pain and positioning. The DON stated repositioning was always an expectation for this resident, and could help alleviate his discomfort. The DON stated there was a "short care plan" online for staff to access to direct them as to this issue for Resident #6. When informed of the surveyor's observations, the DON stated, "I have noticed that myself over the past couple of days. Yesterday I offered at some point to reposition him." The DON and Administrator stated they felt many of Resident #6's pain behaviors, such as grimacing, agitation, and calling out, were to get attention from the staff and not necessarily indicative of pain. On 2/14/13 at 6:45 PM, the Administrator and DON were informed of the surveyor's findings. On 2/22/13 at 4:27 PM, the facility faxed a page from Resident #6's September 2012 care plan. However, this information did not resolve the concern. 2. Resident #9 was admitted to the facility on 2/8/11 with multiple diagnoses including atrial fibrillation, dementia, and hypertension. Physicians order, dating back to 11/7/11 documented, to give MOM (Milk of Magnesia) as needed on the third day without a BM (Bowel Movement) and a Ducolax Suppository on the	F 309	The CQI will start April 1, 2013 The Health Information department will pull a report monthly x 3 months to audit: - Report of all diet orders and supplement orders and with the RN Manager these will be audited to ensure that supplement order is consistent with diet texture and liquid thickness orders. 5. Date Corrective action will be completed: April 15,2013	

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F 309	Continued From page 50 fourth day if no BM. Resident #9's 2013 Bowel and Bladder Report, documented the resident had a bowel movement on 1/30/13 and then six days later on 2/5/13. Resident #9 ' s February 2013 MAR, documented the resident received the MOM on 2/2/13 as ordered, but did not receive the Ducolax Suppository on 2/3/13 as ordered. A facility Investigative Results page, faxed to the Bureau of Facility Standards on 2/21/13 at 4:25 PM, documented, " Documented MOM was given on 02/02/13, following suppository not documented, interview with nurse in charge revealed that she had intended on giving suppository, however, was interrupted and forgot to go back and give the suppository. Nurse in charge will be educated and counseled on this regard. " The information provided by the facility did not resolve the concern 3. In a complaint received by the Bureau of Facility Standards on 2/11/13, the complainant documented that Resident #14 was admitted to the facility in November 2012, and then his health began to decline because of poor care. On 12/2/12, the resident was admitted to the hospital with pneumonia and sepsis. Resident #13 was admitted to the facility on 11/2/12 with diagnoses including traumatic brain injury (1998), seizure disorder, spastic quadriplegia, neurogenic bowel and bladder, history of multiple upper respiratory infections, history of oral pharyngeal dysphagia with	F 309		

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F 309	Continued From page 51 aspiration pneumonia, and a history of multiple urinary tract infections. Physician's admission orders, dated 11/2/13 included, "Pureed with NTL [Nectar Thick Liquids]." A 11/6/12 Physicians Order added, "2Kal 2 oz BID (two times per day)." This was increased to QID (four times per day) on 11/13/12. The resident's 11/8/12 admission MDS assessment coded the resident was totally dependent upon staff for eating/drinking, coughed/choked during meals or when swallowing medications and required textural changes in food or liquids. The resident's Plan of Care, dated 11/14/12, listed the problem, "... Risk for aspiration r/t [related to] swallowing difficulty... " The goal for the problem was, "[Resident #14] will tolerate diet texture [without] s/sx [signs/symptoms] of aspiration." Approaches included: * "Regular puree [diet] with NTL." * "Require one on one [assistance] with minimal distraction." A 11/6/12 Nurses Progress Notes (NN) documented the resident's family voiced the concern that the 2Kal was, "not thick enough." An order to discontinue (DC) the 2Kal was written on 11/6/12 and then later was marked, "Voided." The resident's record failed to document the circumstances of the family's voiced concern, why the order to DC the 2Kal was voided, any assessment completed to evaluate the thickness of the 2Kal versus NTL consistency. Note: During a telephone interview on 3/4/13, the Acting	F 309		

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F 309	Continued From page 52 Director of Nursing (ADON) stated she had recently seen a demonstration by a speech therapist on NTL consistencies. The ADON stated that 2Kcal was observed to be thicker than water but not as thick as the NTL consistency prepared by the speech therapist. In addition, there was no documentation in the November 2012, NNs or the MARs/TARs that the nurses actually thickened the 2Kal before administering it BID (two times per day). The same is true when the 2Kal order was increased from BID to QID (four times per day)on 11/13/12. When increased 3 of the doses were given with meals and the remainder by the LNs. On 11/14/12 NN documented, "Speech therapy advised this [LN] to hold the 2Kal r/t increased cough while giving 2Kcal... " Corresponding Speech Therapy notes, dated 11/14/12, documented, "Discussed need for truly nectar thick liquids vs [versus] naturally nectar thick liquids; demo [demonstration] provided [with] staff expressing understanding of [information] provided... discussed inappropriately thin fluids served [with] kitchen staff, education provided [with] staff expressing understanding. Kitchen to order enriched puddings vs 2Kal, ice cream, and Boost/Ensure drinks." Note: The resident's Care Plan was updated on 11/16/12 listing the problem of, "Severe difficulty swallowing." The goal documented, "To find best food and fluid consistency." The approach included, "DC [discontinue] Ensure, 2 cal [sic].. " Based on a NN written by Resident #14's RN Care Manager on 11/16/12, the resident began	F 309		

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F 309	Continued From page 53 showing signs and symptoms of aspiration pneumonia on 11/16/12. NNs dated 11/16/12 documented the resident's temperature was 99.9 degrees and he had fine rales to his right lung base. The resident's physician was notified and ordered an antibiotic to be given STAT (immediately) and then daily. The resident was to be sent to the ER (Emergency Room) if his temperature went above 100.6 or if not better by, "tomorrow." NNs dated 11/17/12 through 12/2/12 documented the resident was transferred to the ER on 11/18/12, because of supra pubic catheter issues. The resident's respiratory condition stabilized (no increased temperature, no worsening lung sounds, or respiratory/oxygen status) until 11/29/12. On 11/29/12 at 11:00 pm, the resident was transferred to the ER for, "Eval & TX [evaluation and treatment] of a temperature over 100.6, congested lung sounds with bilateral rattles." The resident returned to the facility on 11/30/12 at 2:25 am with antibiotic orders for pneumonia and a urinary tract infection. 11/30/12 - 12/2/12 NNs documented the resident's condition did not improve and "Rapidly declined" on 12/2/12. Resident #14 was transferred to the hospital on 12/2/12 with, "greatly [increased] labored breathing, low oxygen saturation levels, and a temperature of 102." The resident remained in the hospital until 12/13/12 where according to a hospital Discharge Summary dated 12/13, he was treated for pneumonia (non specified) and urosepsis. During an interview on 3/4/12 at 10:20 am, the ADON was notified that there still unresolved concerns regarding the NTL/Liquid supplement	F 309		

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F 309	Continued From page 54 issues. No further documentation was provided. On 3/5/12 at 11:46 am, the Acting Administrator, the new ADON, the VA Director of Social Work, and two additional consultants were notified of the deficient practice. No additional information or documentation was provided which resolved the concern.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide for personal hygiene (bathing) for 3 of 13 sampled residents (#1, 3, & 12) who were unable to carry out this activity of daily living. This failed practice had the potential to result in poor hygiene, odors and skin integrity problems. Findings included: 1. Resident #3 was admitted to the facility on 5/30/12, and readmitted on 10/1/12, with multiple diagnoses including Parkinson's disease, paralysis agitans, and fracture right ankle. The resident's admission MDS assessment, dated 10/9/12, coded: * BIMS score of 11 indicating moderately impaired cognitive skills for daily decision making * Required physical help of one person in part of	F 312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS This requirement was not met as evidenced by the determination that the facility failed to provide for personal hygiene (bathing) for 3 of 13 sampled residents (#1, 3, & 12) who were unable to carry out this activity of daily living. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility is unable to go back and make up these bath/showers. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. All nursing staff was re-educated regarding the bathing procedure 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. The ISVH-L Bathing Procedure has been updated. The facility has now designated a full time day shift and a full time evening shift bath CNA, Monday through Friday. Updated the facility bath/shower schedule to accommodate resident preferences for a Monday through Friday bath/shower routine.	

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F 312	Continued From page 55 bathing activity Resident #3's Resident Plan of Care documented the problem, dated 6/7/12, "Self Care Deficit in bathing..." Interventions included, "Bathe 2x [2 times] per bath schedule, needs one person assist for transfer into bathing area and to complete bathing." NOTE: The bath schedule was weekly. Resident #3's Bath Type Detail Report documented the resident had a shower on 11/16/12 and then was not bathed again until he had a shower documented on 12/4/12, 18 days later. On 2/13/13 at 2:50 pm, the DON was interviewed regarding the baths. She said the resident may have refused a shower during that time and there may be other documentation in the nurses notes regarding refusals. She stated she would review the record. On 2/14/13 at 10:40 am, the DON stated the Behavior Detail Report for 11/20/12 documented Resident #3 had "physically resistive behaviors" and "refused bath or shower" on 11/20/12. The DON said there was no documentation that the resident was offered/reproached to shower or bathe at a different date or time during those 18 days. She stated there was no nursing note indicating the initial bathing refusal or subsequent refusals. She said there was no documentation of care planned approaches when the resident refused to bathe. On 2/15/13 at 1:00 pm, the Administrator and DON were made aware of the issue. The facility	F 312	The facility now designates a bath CNA for day shift and evening shift - Monday through Friday, the designated bath aide for the day/eve shift will utilize the "Skin and Bath Report" sheet and list each resident that they will bathe or shower on their assigned shift. With the use of the Skin and Bath Report the bath CNA will document that they did each of the assigned bath/shower and that the bath/shower was documented in the Care Tracker Software prior to the end of the designated bath CNA's assigned shift. The RN Manager will then review the Skin and Bath Report sheet and audit Care Tracker Software to ensure that the bath/shower was documented. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. To begin 3/25/13, the RN Manager or her designee will generate a ISVH-L Bath Type Detail Report from the Care Tracker software to ensure that the assigned baths were documented for the previous week. This will be done q week x 4 weeks, then q 2 weeks x 4 weeks and then q month x 3 months. The RN Manager will bring any issues identified to the DNS and Administrator. CQI Skin Wound Care has been modified to include item to audit resident bathing and documentation of bath/shower. Once the above audits have been completed this CQI will be done biannually. 5. Date Corrective action will be completed: April 15, 2013	

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F 312	Continued From page 56 provided no other information or documentation that resolved the concern. 2. Resident #12 was admitted to the facility on 2/15/11 with diagnoses including Alzheimer's Disease. The resident's quarterly MDS assessment, dated 9/24/12, coded: * BIMS score of 10 indicating moderately impaired cognitive skills for daily decision making * Required physical help of one person for part of the bathing activity. Resident #12's Bath Type Detail Report documented the resident had a shower on 12/5/12 and then did not bath again until she had a shower documented on 12/15/12, 10 days later. The facility sent a faxed document to the survey team on 2/19/12 at 10:47 am which documented an unsigned, undated, hand written note that read, "Rsdt [resident] acutely ill in Nov. [November] 1 bath/wk [one bath per week]. Charting as to ref. [refusal] to get up OOB [out of bed]. See attached." Resident #12's Nursing Progress Notes were faxed along with the note. The Nursing Progress Notes were dated from 11/11/12 to 11/16/12 and provided no information from 12/5/12 to 12/15/12 when the resident did not have a shower. The facility provided no other information or documentation that resolved the concern. 3. Resident #1 was admitted to the facility on 2/14/12 with diagnoses including dementia with behavioral disturbance.	F 312		

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F 312	Continued From page 57 The resident's most recent quarterly MDS assessment, dated 10/15/12, coded: * BIMS score of 15 indicating cognitively intact * Required physical help of one person in part of bathing activity Resident #1's Plan of Care documented the problem, dated 2/22/12, "Self Care Deficit in bathing..." Interventions included, "Bathe 2 x per bath schedule, independent with transfer into bathing area and one person assist to complete bathing." Resident #1's Bath Type Detail Report documented the resident had a shower on 12/5/12 and then was not bathed again until he had a shower documented on 12/15/12, 10 days later. The resident's Compressed Behavior Report documented the resident did not reject care during this period of time. On 2/15/13 at 1:00 pm, the Administrator and DON were informed of the issue. The facility provided no other information or documentation that resolved the concern.	F 312		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	F 329 DRUG REGMEN IS FREE FROM UNNECESSARY DRUGS Each resident' s drug regimen must be free from unnecessary drugs. Any unnecessary drug is any drug when used is excessive dose (including duplicate therapy) or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate to dose should be reduced or discontinued or any combination of the reasons above.	

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F 329	Continued From page 58 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not ensure residents were free from unnecessary medications. This was true for 1 of 10 residents (Resident #17) sampled for drug regimen. Resident #17 was harmed when he experienced behavioral changes leading to an increase in one of his psychotropic medications (Depakote), and the addition of 3 more medications (Ativan, Namenda, and Clonipramine). The facility did not document a thorough investigation of the root causes of the resident's behavioral changes. The unnecessary use of these medications led to adverse reactions of increased lethargy, increased confusion, increased sleeping during the day, and pill rolling. It was ultimately discovered that the facility substantiated an allegation of abuse towards this resident on	F 329	Based on comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug therapy is necessary is necessary to treat a specific condition as diagnosed and documented in the clinical record and residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #17 was affected by this deficient practice. Based on review of the facility' s abuse policy, review of investigations, review of personnel files, record review, and staff interviews, it was determined that the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were immediately reported, residents were immediately protected, allegations were thoroughly investigated and appropriate corrective action was taken.. Resident #17 medications were reduced when the LN #19 was discharged from employment at the ISVH Lewiston. His behaviors have continued post her discharge but have not been document to the levels they were when LN #19 was an employee. LN #19 was notified by certified mail the conditions that she is allowed to visit her relative in order to maintain resident #17' s safety during her visits. Staff has been educated on the procedure of ensuring resident #17 is not in contact with former employee, LN #19, while she is in the building. Leadership will monitor former employee, LN #19, if and when she is in the building to ensure she has no contact with resident #17. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	

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F 329	Continued From page 59 8/5/12, and the staff member continued employment at the facility until 9/6/12. Resident #17 successfully tolerated the discontinuation of one of these medications (Clonipramine), a reduction of another (Depakote), and reduced usage of "as needed" Ativan after the identified employee was terminated from the facility. Findings included: NOTE: Please see F 225, F 226, and F 490 pertaining to abuse and facility administration. Resident #17 was admitted to the facility on 12/9/09 with diagnoses including Alzheimer's disease and depression. Resident #17's Quarterly MDS dated 9/10/12 coded: -BIMS of 8, indicating moderately impaired cognitive skills -No indicators of depression -No behavioral symptoms -Extensive assistance of 1 person for transfers and ADL's -Able to propel his wheelchair independently Resident #17's Quarterly MDS dated 12/3/12 coded: -BIMS of 10, indicating moderately impaired cognitive skills -No indicators of depression -No behavioral symptoms -Extensive assistance of 1 person required for transfers and most ADL's -Able to propel his wheelchair independently Resident #17's 8/1/12 Physician's Orders (recaps) included:	F 329	All residents have the potential to be negatively impacted by this deficient practice. As a result, Reasonable Suspicion of a Crime Policy has been reviewed and revised to ensure consistency with Administrative Policy, State, and Federal Regulations. All of the staff were in-serviced regarding the deficient practice on February 28, 2013 and March 20, 2013 via multiple all staff meetings. Nursing staff received additional in-services on March 6, 7 & 8, 2013 and through silent in-services. All new allegations of abuse, neglect or mistreatment have been reported to State survey and certification agency. All individuals involved in the abuse allegation have been placed on administrative leave pending the outcome of the investigations. Results of the investigation have been reported to the State survey and certification agency. The Director of Social Services from Boise has conducted resident interviews of approximately 50% of the residents to identify concerns of abuse, neglect or mistreatment. No new issues were identified during this process. All residents will have their behaviors monitored and behavioral management plans will be developed by social services staff and educated to ensure that behaviors are documented to identify triggers so that non-pharmaceutical interventions can be implemented. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All staff has been in-serviced regarding the updated policy and the behavioral expectations of reporting any alleged abuse, neglect or mistreatment of residents. Leadership has been transitioned to an interim staff to ensure the appropriate identification and investigation of alleged complaints of abuse, neglect or mistreatment. Future leadership will be extensively in-serviced regarding the behavioral expectations for reporting abuse allegations to all the appropriate	

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F 329	Continued From page 60 -Celexa 40 mg daily for depression -Depakote 125 mg twice daily -Buspar 5 mg twice daily for agitation Resident #17's MD progress note dated 8/15/12 documented, "His dementia is worsening and now having behaviors. These behaviors pertain to an inappropriate fixation on one of our nurses. I have attempted to handle this non-medicinally with re-direction, verbal cuing, etc., however this has been fruitless and we've had to bet the psychiatric staff involved...[RN Manager] is involved and we have already outlined her concerns." Medication changes from August through October 2012 included: 8/15/12: -Depakote 125 mg twice daily discontinued, Depakote 250 mg three times daily started. [NOTE: This increased Resident #17's total daily dose from 250 mg per day to 750 mg per day.] -Buspar discontinued -New order for lorazepam 0.5 mg every 4 hours as needed. -New order for Namenda 5 mg twice daily for 4 weeks, then increase to 10 mg twice per day 8/29/12: -New order for Clonipramine 25 mg daily for 7 days, then increase to 50 mg daily 10/10/12: -Clonipramine discontinued 11/6/12 -Depakote 250 mg TID discontinued, with the dosage reduced to 125 mg TID Resident #17's MAR for August 2012 documented lorazepam administered on 8/25/12	F 329	agencies as well as Division staff to ensure that reporting requirements are met. Any identified failures to report abuse according to policy will be address as a performance issue with staff. Residents with behavioral concerns will have a behavior management plan and silent in-services will be used to reeducate the staff on behavior modification techniques. Staff has been in-serviced to the updated behavioral management plans for effective implementation. Social Service has had their policy manual extensively revised to address the current practice and expected professional practice. They will be extensively involved in developing the behavior management plans that determine the triggers for behaviors and effective diversionary actions will identified. Social Services will be documenting these non-pharmaceutical interventions in the residents care plan. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The interventions and in-servicing by the interim staff have created an environment in which abuse allegations are reported by all staff. Future leadership staff will be extensively in-serviced to ensure understanding of the policy and all behavioral expectations included in the policy. Idaho Division of Veterans Services staff will monitor this process on a monthly basis for the next 12 months through review of the reported polices, staff interviews, review of documentation to ensure policies are followed and abuse allegations are reported. Residents behaviors and interventions will be monitored at the psychotropic medication management meetings and behavioral triggers will be a key elements for all residents monitored in through this process. This will be an ongoing process. 5. Date Corrective action will be completed: April 15,2013	

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F 329	Continued From page 61 at 9:00 AM and 8/27/12 at 8:20 AM. Lorazepam was not documented as given in September or October 2012. Resident #17's Nursing Progress Notes (PNs) documented: -8/8/12 at 9:00 AM. "Resident follows LN [LN initials] around and is asked to leave politely but refuses...PRN Buspar given [with no] noticeable results." -8/12/12 at 2:20 PM. [NOTE: The following entry was made by the staff member later discovered to have been abusing this resident.] "During lunch rsdt [resident] was whistling to get this writers attention. When I finally looked rsdt flips this writer off and proceeds to make measurements [with] his hands referring to the size of his penis...Rsdt wheeled from dining room [and] immediately returns...wanting to speak to this LN...rsdt continues to resist leaving dining room...follows this writer. CNA tried to redirect rsdt from this LN, rsdt resisted, cursing and calling CNA names [and] proceeded to ram her [with] his w/c until she moved. This LN asked rsdt to go, he was being inappropriate [and] that he couldn't attack staff. Rsdt finally went to his room." -8/15/12 at 10:50 PM. "Started on increased Depakote as ordered..." -8/17/12 at 3:30 PM. "[Increased] Depakote and Namenda continue...Has been noted to be sleeping more today. Frequently falling asleep sitting the day area in w/c. [At] times mumbling/talking in sleep." -8/25/12 at 1:15 PM. [NOTE: The following entry was made by the staff member later discovered to have been abusing this resident.] "Rsdt cont to	F 329		

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F 329	Continued From page 62	F 329		

follow this LN, wanting to ask '1 question.' When redirected activities explained that LN was busy...rsdt back on north hallway. When CNA attempting to re-direct rsdt, rsdt threatening to stand up [and] hurt CNA [and] threw a cup of [water] onto CNA..."
-8/25/12 at 3:35 PM. "RN reports resident aggressive [with] agitation [and] anger [with] swinging [at] CNA [and] also cursing...continues to be aggressive toward RN...Ativan given X 1 [and] resident fell asleep for approx 2 hrs."
[NOTE: The RN referred to in the above entry is the staff member later discovered to have abused this resident.]
-8/27/12 at 7:00 AM. "...Staring at nurse or looking in at her. [LN name] states she's been talking to him [and] requested he be wheeled away. Attempted to move or wheel rsdt away [and] rsdt refused to put feet down...PRN Ativan given to try to alleviate situation."

[NOTE: On both occasions Resident #17 received Ativan, he was either in the presence of the staff member later found to have abused him, or had been documented to have been in her presence, with agitation present, within the past 2 1/2 hours.]

Resident #17's PNs continued:
-9/1/12 at 11:00 PM. "[No] behavior problems..."
-9/2/12 at 3:30 PM. "Happy [and] pleasant..."
-9/21/12 at 2:30 PM. "Does sleep often throughout the day. [Increased] STML [short-term memory loss] this AM..."
-10/8/12 at 2:40 PM. "Res[ident] with [increased] lethargy this shift. Res sleeping in wc with hands curling in [at] the wrists...res cogwheeling. Res [with increased] confusion grasping [at] things

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F 329	Continued From page 63 [and] pill rolling while sleeping..." -10/9/12 at 2:15 PM. "Res slept 5 [hours] this shift. While sleeping res reaching out [with] hands 'pill rolling' fingers, posturing hands...slightly confused when woke..." -10/10/12, time illegible. "N.O. [new order] d/c Clomipramine." -10/10/12 at 1:50 PM. "Held Depakote X 2 [twice] this shift. Res slept 2 [hours] this shift..." On 2/14/13 at 12:40 PM, the surveyor asked to see facility abuse investigation files as part of the standard abuse task. LSW #1 provided an investigation which documented LN #19 abused Resident #17, with an onset date of 8/5/12. LN #19 continued employment at the facility until 9/6/12, with her last date of contact with Resident #17 as 8/27/12. LSW#1 was asked for any additional information regarding the reporting and investigation of this information, including a facility incident report. LSW #1 stated there was no additional information beyond what was already provided. On 2/15/13 at 9:07 AM, LN #10 was interviewed regarding Resident #17's medication changes. LN#10 stated the facility had requested the physician order a medication review because Resident #17 had an infatuation with a nurse and became upset if that nurse did not work with him. On 2/15/13 at 1:15 PM, Resident #17's physician was interviewed regarding medication changes for this resident in light of the abuse event. The MD stated the medications were added per request of facility nursing staff, most likely LN #10 or the RN Manager. The MD stated he was informed that Resident #17 had "sexual	F 329		

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F 329	Continued From page 64 behaviors" towards a LN #19, but had not been informed of the LN's behaviors towards the resident. The MD stated he had been informed LN #19 and Resident #17 would be kept separate form one another. The MD stated he would normally be informed of such things through a facility incident report, although he did not see an indictment report of abuse in this case. The MD reported the resident had no other behaviors contributing to the increase or addition of medications. The MD stated Resident #17 has not had any behavioral symptoms since the time LN #19 left the facility. On 2/19/13 at 2:10 PM, the Administrator and DON were informed of these findings. The facility offered no further information.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure it did not have a medication error rate greater than 5%. This was true for 3 of 41 medications (7.3%) which affected 3 of 5 residents (#s 18, 19, &21) during medication pass observations. Specifically, potassium chloride extended release tablet was crushed and administered to Resident #18, bronchodilator and steroid inhalations were	F 332	F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE This requirement was not met as evidenced by the determination that the facility failed to ensure it did not have a medication error rate greater than 5%. This was true for 3 of 41 medications (7.3%) which affected 3 of 5 residents (#18, 19, & 21) during medication pass observations. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility is unable to go back and correct the deficient practice that was observed. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. All Licensed nursing staff have been in-serviced on medication administration - specifically including how to	

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F 332	Continued From page 65 administered incorrectly to Resident #21, and omeprazole was administered with food instead of before meals to Resident #19. These failed practices had the potential to reduce the therapeutic benefits of the medications. (Refer to F333 as these errors constituted significant medication errors). Findings included: 1. Resident #18 was admitted to the facility on 2/11/13 with diagnoses including hypertension and cerebral artery occlusion with infarct. During a medication pass observation on 2/12/13 at 8:50 am, LN #14 was observed administering KCl 20 meq ER (potassium chloride 20 millequivelants, extended release) to Resident #18 as ordered by the physician. LN #14 removed the KCl tablet from the blister package, labeled as above, placed the tablet in a medicine cup with other medications, crushed all of the medications in the cup and administered the medications to Resident #18. Potter and Perry, 7th Edition, 2009, state on page 708 in the Safety Alert, "Nurses cannot crush all medications. Some medications, such as time-released or extended-release capsules, have special coatings to prevent the medication from being absorbed too quickly." 2. During the medication pass observation on 2/12/13 at approximately 9:48 to 9:52 am, LN #15 was observed administering the inhaled steroid medication QVAR, 80 milligrams (mg), 2 puffs and the inhaled bronchodilator, Spiriva, 18 mg to Resident #21 as ordered by the physician. LN #15 handed Resident #21 the QVAR first at approximately 9:48 am and instructed the	F 332	identify medications that should not be crushed, proper sequence of MDI. On 2/14/13 the ISVH-L Pharmacy stated that they will begin putting "do not crush" labels on blister packages when appropriate. The ISVH nursing and Health Information Management departments met with the ISVH-L pharmacist and Medical Director and it was determined for medication such as PPI (e.g. Prilosec) that the administration time for these medications will be set to accommodate an empty stomach as per manuf. guidelines. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Medication Administration and Medication Orders procedure has been revised, this procedure includes the facility procedure for the Administration of Metered Dose inhalers - including MDI sequence. All licensed nursing staff have been in-serviced to this procedure. Additionally a more detailed in-service has been given to all the licensed nursing staff regarding how to properly administer a MDI. A flow chart for administering multiple inhaled medications has been developed in conjunction with the pharmacist and all nursing staff have been in-serviced to this flow chart. This flow chart will be placed at the front of each MAR on each medication cart. All residents who have a prescription for MDI have been identified and specific perimeters are being placed with these MDI orders on the MAR to ensure that the MDI is given per the proper perimeters such as sequence of inhalers, time between puffs, and rinsing out mouth with water and spitting out the water in the case of a steroid inhaler. A list of medications that should not be crushed has been placed at the front of every MAR. The facility pharmacist will check this list monthly and update as needed.	

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F 332	Continued From page 66 resident to take one puff. LN #15 waited approximately 2 minutes and handed the resident the Spiriva inhaled medication. The resident inhaled that medication. LN #15 waited approximately 2 minutes and handed the resident the QVAR inhaler again and instructed the resident to take another puff. Perry & Potter, 7th Edition, 2010, in Clinical Nursing Skills & Techniques, documented on page 559, "...Drugs must be inhaled sequentially. If bronchodilators are administered with inhaled steroids, the bronchodilators should be given first in order to dilate the airway passages for the second medication." 3. Resident #19's Physicians Orders for 2/2013 documented, "Omeprazole 20 mg, 1 PO Q day [20 milligrams, 1 dose by mouth every day]." On 2/12/13 at 9:05 am, LN #7 was observed administering omeprazole 20 mg by mouth to Resident #19 after the breakfast meal. S&C: 13-02-NH, Nursing Homes - Clarification of Guidance related to Medication Errors and Pharmacy Services documented on page 3, under the title Proton Pump Inhibitors (PPI), "...The facility must have policies that address the timing for medications that are required to be administered with regard to food intake (for example, with food or on an empty stomach). PPIs such as ...omeprazole (Prilosec), are routinely used in nursing home settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system	F 332	The facility pharmacist and pharmacy staff have begun labeling medications that should not be crushed with "Do Not Crush" labels and as of 3/21/13 they will have affixed these "Do Not Crush" labels to all appropriate medications currently in use on the medication carts. All residents in the facility that take Prilosec or other PPI medication that should be taken on an empty stomach have been identified and in consultation with their attending physician these medication times have been adjusted so that the administration can be given on an empty stomach. All future PPI medication orders will be scheduled to be administered prior to meals. All licensed nursing staff will be evaluated using the ISVH-L Medication Administration Skills Assessment. This assessment evaluates the nurse in multiple areas during medication administration including but not limited to locking the medication cart when not in use, using the dot system when administering medication, administering medications at proper time, appropriate crushing of medication, and proper administration of inhaled medication. If areas of poor technique are identified then that nurse will receive individual in-service based on need and re-evaluated. The CQI Pharmacy Services has been modified to include item to audit that the medications that should not be crushed sheet is present in each MAR and updated monthly by the pharmacist and do not crush labels are being placed on appropriate resident 'blister package' medication by pharmacy. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Health Information department will pull a report monthly x 3 months to audit: - PPI's are scheduled for proper administration times and - MDI orders include proper sequence instructions as per flow sheet	

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F 332	Continued From page 67 before food activates the acid pumps so that the peak concentration of PPI will coincide with maximal acid secretion. Some residents may report benefits of this medication being administered outside the 30-60 minutes prior to a meal and this needs to be determined and documented to justify the continues administration times." On 2/15/13 at 1:00 pm, the Administrator and DON were informed of the issues listed above. The facility faxed a document to the survey team on 2/21/13 at 4:25 pm regarding the administration of omeprazole from the Mayo Clinic website. The information provided by the facility did not resolve the concern.	F 332	The Administrator will monitor the CQI Pharmacy Services This CQI will be done q week x 4 weeks, then q month x 3 months, then every three months. The CQI will start March 25, 2013 Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration Skills Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor technique are identified then that nurse will receive individual in-service training based on need and re-evaluated. 5. Date Corrective action will be completed: April 15, 20130	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of the facility ' s Nursing Procedure Manual, it was determined the facility failed to ensure there were no significant medication errors. This was true during medication pass observations of 3 of 3 LNs who either crushed an extended release tablet and administered the medication to Resident #18, gave Resident #21 inhaled steroid medication before administering the inhaled bronchodilator, and/or administered a proton pump inhibitor to Resident #19 after breakfast. These failed practices had the potential to reduce the	F 333	F 333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS This requirement was not met as evidenced by the determination that the facility failed to ensure there were no significant medication errors. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility is unable to go back and correct the deficient practice that was observed. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. All Licensed nursing staff have been in-serviced on medication administration – specifically including how to identify medications that should not be crushed, proper sequence of MDI. On 2/14/13 the ISVH-L Pharmacy stated that they will begin	

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F 333	Continued From page 68 therapeutic benefits of the medications. Findings included: 1. Potter and Perry, 7th Edition, 2009, state on page 708 in the Safety Alert, "Nurses cannot crush all medications. Some medications, such as time-released or extended-release capsules, have special coatings to prevent the medication from being absorbed too quickly." The facility's Nursing Procedure Manual reference, provided by the Administrator on 2/13/13 at 8:50 am, documented, on page IX-5, "...9. Do not crush medications that should not be crushed unless the physician or pharmacist has explained, in the clinical record, why crushing the medication will not adversely affect the resident..." During a medication pass observation on 2/12/13 at 8:50 am, LN #14 was observed administering KCl 20 meq ER (potassium chloride 20 millequivelants, extended release) to Resident #18 as ordered by the physician. LN #14 removed the KCl tablet from the blister package, labeled as above, placed the tablet in a medicine cup with other medications, crushed all of the medications in the cup and administered the medications to Resident #18. After LN #14 administered the medication, he was asked to re-read the label on the KCl blister package and explain how the medication was to be administered. When specifically asked about the "ER" on the label, he said he did not know what that meant. He then looked at the MAR and said, "I think it means extended release." When asked what "extended release" meant, he said it	F 333	putting "do not crush" labels on blister packages when appropriate. The ISVH nursing and Health Information Management departments met with the ISVH-L pharmacist and Medical Director and it was determined for medication such as PPI (e.g. Prilosec) that the administration time for these medications will be set to accommodate an empty stomach as per manuf. guidelines. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Medication Administration and Medication Orders procedure has been revised; this procedure includes the facility procedure for the Administration of Metered Dose inhalers - including MDI sequence. All licensed nursing staff have been in-serviced to this procedure. Additionally a more detailed in-service has been given to all the licensed nursing staff regarding how to properly administer a MDI. A flow chart for administering multiple inhaled medications has been developed in conjunction with the pharmacist and all nursing staff have been in-serviced to this flow chart. This flow chart will be placed at the front of each MAR on each medication cart. All residents who have a prescription for MDI have been identified and specific perimeters are being placed with these MDI orders on the MAR to ensure that the MDI is given per the proper perimeters such as sequence of inhalers, time between puffs, and rinsing out mouth with water and spitting out the water in the case of a steroid inhaler. A list of medications that should not be crushed has been placed at the front of every MAR. The ISVH-L pharmacist will check this list monthly and update as needed. The facility pharmacist and pharmacy staff have begun labeling medications that should not be crushed with "Do Not Crush" labels and as of 3/21/13 they will have affixed	

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F 333	Continued From page 69 meant the medication should not be crushed, but that, "I did crush it." Pharmacist #13 was interviewed on 2/13/13 at 10:15 am. He agreed that extended release medication should not be crushed. He said the pharmacy does not identify the medication on the blister package label as a "Do not crush" medication, but thought the nurses have "a list somewhere" that tells them which medications should not be crushed. Pharmacist #12 was interviewed on 2/14/13 at 12:30 pm. He agreed that extended release medication should not be crushed. He said the pharmacy will begin to put labels on the blister packages that say, "Do not crush" when appropriate. 2. Perry & Potter, 7th Edition, 2010, in Clinical Nursing Skills & Techniques, documented on page 559, "...Drugs must be inhaled sequentially. If bronchodilators are administered with inhaled steroids, the bronchodilators should be given first in order to dilate the airway passages for the second medication." On 2/13/13 at 8:50 am, the Administrator stated the facility did not have a policy/procedure for administering drugs by inhalation. She handed the survey team a policy called, "Administration of Metered Dose Inhalers (MDI)," dated 2/13/13, which she described as a "new" policy. The policy documented, "...8. When a resident utilizes both a bronchodilator and a steroid MDI, the bronchodilator MDI is administered first to open the airway."	F 333	these "Do Not Crush" labels to all appropriate medications currently in use on the medication carts. All residents in the facility that take Prilosec or other PPI medication that should be taken on an empty stomach have been identified and in consultation with their attending physician these medication times have been adjusted so that the administration can be given on an empty stomach. All future PPI medication orders will be scheduled to be administered prior to meals. All licensed nursing staff will be evaluated using the ISVH-L Medication Administration Skills Assessment. This assessment evaluates the nurse in multiple areas during medication administration including but not limited to locking the medication cart when not in use, using the dot system when administering medication, administering medications at proper time, appropriate crushing of medication, and proper administration of inhaled medication. If areas of poor technique are identified then that nurse will receive individual in-service based on need and re-evaluated. The CQI Pharmacy Services has been modified to include item to audit that the medications that should not be crushed sheet is present in each MAR and updated monthly by the pharmacist and do not crush labels are being placed on appropriate resident 'bubble pack' medication by pharmacy. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Health Information department will pull a report monthly x 3 months to audit: - PPI' s are scheduled for proper administration times and - MDI orders include proper sequence instructions as per flow sheet The Administrator will monitor the CQI Pharmacy Services This CQI will be done every month x 4 months, then every three months x 6 months, and biannually after that.	

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F 333	Continued From page 70 During the medication pass observation on 2/12/13 at approximately 9:48 to 9:52 am, LN #15 was observed administering the inhaled steroid medication QVAR, 80 milligrams (mg), 2 puffs and the inhaled bronchodilator, Spiriva, 18 mg to Resident #21 as ordered by the physician. LN #15 handed Resident #21 the QVAR first at approximately 9:48 am and instructed the resident to take one puff. LN #15 waited approximately 2 minutes and handed the resident the Spiriva inhaled medication. The resident inhaled that medication. LN #15 waited approximately 2 minutes and handed the resident the QVAR inhaler again and instructed the resident to take another puff. On 2/14/13 at 10:10 am, LN #15 was interviewed regarding the above observation. He said he did not know what order the inhaled medications should be given, but had read the new policy regarding the issue. On 2/13/13 at 10:15 am, Pharmacist #13 was asked about administering inhaled steroids and bronchodilators. He said that the bronchodilator should be administered first and then the steroid medication. He stated that information should be on the resident's MAR. On 2/14/13 at 12:30 pm, Pharmacist #12 was asked about administering inhaled steroids and bronchodilators and told of the medication pass observation. He stated that the bronchodilator should be given first to optimize the medications effectiveness. He said he has not given any inservices regarding administration of inhalers.	F 333	The CQI will start April 8, 2013 Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration Skills Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor technique are identified then that nurse will receive individual in-service training based on need and re-evaluated. 5. Date Corrective action will be completed: April 15, 2013	

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F 333	Continued From page 71 3. S&C: 13-02-NH, Nursing Homes - Clarification of Guidance related to Medication Errors and Pharmacy Services documented on page 3, under the title Proton Pump Inhibitors (PPI), "...The facility must have policies that address the timing for medications that are required to be administered with regard to fool intake (for example, with food or on an empty stomach). PPIs such as ...omeprazole (Prilosec), are routinely used in nursing home settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30-60 minutes before meals. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pumps so that the peak concentration of PPI will coincide with maximal acid secretion. Some residents may report benefits of this medication being administered outside the 30-60 minutes prior to a meal and this needs to be determined and documented to justify the continued administration times." Nursing2013 Drug Handbook, 33rd Edition, 2013, documented on page 1011 the following regarding the administration of omeprazole tablets, capsules and powder, "Give drug at least 1 hour before meals." The facility's Nursing Procedure Manual documented under Standard Medication Times and Orders, "1. In collaboration with the physician, the nurse may change standard medication times ..." Resident #19 ' s Physicians Orders for 2/2013 documented, "Omeprazole 20 mg, i PO Q day [20	F 333		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 72 milligrams, 1 dose by mouth every day]." On 2/12/13 at 9:05 am, LN #7 was observed administering omeprazole 20 mg by mouth to Resident #19 after the breakfast meal. On 2/13/13 at 8:50 am, the Administrator stated the facility does not have a policy or procedure regarding the administration of PPIs. On 2/14/13 at 10:45 am, LN #7 was asked about the medication administration time for Resident #19. She stated that omeprazole should be given before meals, but that the physician determines the times of medication administration and, "We don't dare change the times on Prilosec." Note: The physician orders did not specify a time to give the medication, only that the medication be given every day. The facility policy documented the nurse could consult the physician regarding medication administration times. On 2/15/13 at 1:00 pm, the Administrator and DON were informed of the issues listed above. The facility faxed a document to the survey team on 2/21/13 at 4:25 pm regarding the administration of omeprazole from the Mayo Clinic website. The information provided by the facility did not resolve the concern.	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON This requirement was not met as evidenced by the determination that the facility failed to ensure monthly medication regimen reviews documented irregularities with medication administration. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	

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F 428	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure monthly medication regimen reviews documented irregularities with medication administration. This was true for 1 random resident observed during medication pass to receive omeprazole after meals. This failed practice had the potential to reduce the therapeutic benefits of the medications. (Refer to F333). Findings included: Resident #19's Physicians Orders for 2/2013 documented, "Omeprazole 20 mg, i PO Q day [20 milligrams, 1 dose by mouth every day]." The start date for the medication was 9/6/12. On 2/12/13 at 9:05 am, LN #7 was observed administering omeprazole 20 mg by mouth to Resident #19 after the breakfast meal. The medication regimen reviews conducted by the pharmacist for Resident #19's medications were reviewed for 2012 and 2013. The reviews stated that any irregularities found during the review would be sent to the DON. On 2/13/13 at 3:20 pm, the DON was asked if she had any documentation from the pharmacist regarding the administration of omeprazole for Resident #19. The surveyor did not receive any documentation from the DON. On 2/13/13 at 8:50 am, the Administrator stated	F 428	The facility is unable to go back and correct the deficient practice for the resident identified. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. All residents in the facility that take Prilosec or other PPI medication that should be taken on an empty stomach have been identified and in consultation with their attending physician these medication times have been adjusted so that the administration can be given on an empty stomach. All future PPI medication orders will be scheduled to be administered prior to meals. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. The ISVH-L Pharmacist has been provided with a copy of F-428 for his review by the ISVH-L Acting Administrator and he has been asked to sign an acknowledgement that he has received and read F 428. The ISVH-L Physician's Recap procedure has been revised. The Physician orders will be printed six business days prior to the end of the month and a cover page will be placed on each resident's 'recap'. The physician's orders with the cover page will then be routed to the ISVH-L Pharmacist for the Drug Regimen Review. The ISVH-L Pharmacist will review the physician' s orders per guidelines in F 428, document any comments, dosing safety or recommendations on the cover sheet and return the recap to the ISVH-L RN Manager. The RN Manager then reviews the physician' s orders and comment as needed. The recaps are then sent to the residents attending MD for review and signature, to the DNS for review and signature and then lastly to the RN Manager again for final review and signature before they are	

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F 428	Continued From page 74 the facility does not have a policy or procedure regarding the administration of PPIs (omeprazole). On 2/13/13 at 10:15 am, Pharmacist #13 was interviewed regarding omeprazole. He stated Pharmacist #12 does the medication reviews and would be in on 2/14/13 to speak to the survey team. Pharmacist #13 stated that omeprazole should be in the stomach before the meal was eaten. On 2/14/13 at 12:30 pm, Pharmacist #12 was interviewed regarding omeprazole. He stated that, ideally, omeprazole should be given before meals. He stated that in his medication regimen reviews for omeprazole, he concentrated on the "indications" for use of omeprazole and not the times of administration. On 2/15/13 at 1:00 pm, the Administrator and DON were informed of the issue. The facility faxed a document to the survey team on 2/21/13 at 4:25 pm regarding the administration of omeprazole from the Mayo Clinic website. The information provided by the facility did not resolve the concern.	F 428	filed in the residents medical record. The CQI Pharmacy Services has been modified to include item to audit that the pharmacist has conducted monthly drug regimen review. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Starting in the month of April 2013, the ISVH-L Health Information department will review 100% of the monthly physician's orders every month to ensure that the cover page is intact and all signatures are present before the recaps are signed and placed in the resident's medical record. The Administrator will monitor the CQI Pharmacy Services This CQI will be done every month x 4 months, then every three months x 6 months, and biannually after that. The CQI will start April 8, 2013 5. Date Corrective action will be completed: April 15,2013	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS This requirement was not met as evidenced by the determination that the facility failed to ensure the medication cart for the North hall had a functioning lock to secure resident prescription and over the counter medication 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility notified the survey team on 2/14/13 at 10:10 am	

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F 431	Continued From page 75 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the medication cart for the North Hall had a functioning lock to secure resident prescription and over-the-counter medication. This affected 1 of 3 medication carts in the facility. This failed practice had the potential for harm by giving access to medications to residents, visitors, and family. Findings included: On 2/12/13 at 9:20 am, before the medication	F 431	that the North hall medication cart lock had been fixed. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. All medication and treatment carts in the facility have been physically checked by the Acting RN Manager and are found to be locking correctly. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Medication Administration and Medication Orders procedure has been revised, this procedure includes the facility procedure for Medication and Treatment Carts and that these carts are to be kept locked when not in use. All licensed nursing staff were in-serviced to this procedure. All licensed nursing staff will be evaluated using the ISVH-L Medication Administration Skills Assessment. This assessment evaluates the nurse in multiple areas during medication administration including but not limited to locking the medication cart when not in use, using the dot system when administering medication, administering medications at proper time, appropriate crushing of medication, and proper administration of inhaled medication. If areas of poor technique are identified then that nurse will receive individual in-service based on need and re-evaluated. CQI Pharmacy Services has been modified to include item to check all Medication and Treatment carts to ensure lock is working and if it is not identify plan put into place to secure medications and whom notified. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration	

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F 431	Continued From page 76 pass observation, the drawers of the medication cart for the North Hall were observed to be unlocked and unattended. The North Hall medication cart contained prescription and over-the-counter medications for residents residing on the North Hall. LN #15 was observed exiting a resident's room close to the medication cart and was asked about the unlocked/unattended cart. LN #15 said the lock on the cart had been broken for some time, at least for the last few days. He stated he had reported the lock was broken on the medication cart several days ago, but the lock had not been fixed. LN #15 prepared medications to administer to Resident #21. LN #15 went into Resident #21's room leaving the North Hall medication cart in the hallway, unlocked and out of visual contact. He put the call light on in Resident #21's room. CNA #3 answered the light after a few minutes. LN #15 asked CNA #3 to stand in the hallway by the North Hall medication cart while he finished administering the medications to Resident #21 explaining the lock was broken on the cart and the CNA was to watch the cart. After he administered the medications to the resident, he pushed the medication cart into the nurse's station area. On 2/12/13 at 4:10 pm, the Administrator and DON were informed that the North Hall medication cart was not able to be locked. The DON said, "It's been fixed." On 2/14/13 at 10:10 am, LN #15 reported to the surveyor that the North Hall medication cart now had a lock that worked. On 2/14/13 at 12:30 pm, Pharmacist #12 was asked about the lock on the North Hall medication cart. He stated he had seen the North	F 431	Skills Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor technique are identified then that nurse will receive individual in-service training based on need and re-evaluated. The Administrator will monitor the CQI Pharmacy Services This CQI will be done every month x 4 months, then every three months x 6 months, and biannually after that. The CQI will start April 8, 2013 5. Date Corrective action will be completed: April 15,2013	

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F 431	Continued From page 77 Hall medication cart in the hallway with the drawers bumping up against the wall and wondered why the cart was positioned in that fashion. He said he did not know the lock was broken. The facility provided no other information or documentation that resolved the concern.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS This requirement was not met as evidenced by the determination that the facility failed to ensure staff adhered to standard infection control measures. This was true for 1 of 3 LN observed during medication pass, who failed to wash his hands after removing his gloves before and after administering an intravenous medication to Resident #18. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Licensed Nurse #14 has been re-educated about the proper use of gloves and handwashing while administering medications through a PICC line. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who reside in the facility have the potential to be affected by the deficient practice. The entire staff has been in-serviced regarding proper hand washing and gloving techniques. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All glove sizes will be located in each resident room to prevent the need to obtain gloves from the hallway. All licensed nursing staff will be evaluated using the ISVH-L Medication Administration Skills Assessment. This	

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F 441	Continued From page 78 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's hand washing policy, it was determined the facility failed to ensure staff adhered to standard infection control measures. This was true for 1 of 3 LNs observed during medication pass, who failed to wash his hands after removing his gloves before and after administering an intravenous medication to Resident #18. Failure to implement standard infection control measures placed residents at risk for harm from infections due to transmission of microorganisms. Findings included: The facility's Nursing Procedure Manual on "Using Gloves" documented, "...F. Wash hands after removing gloves. Gloves do not replace hand washing. ..." On 2/12/13 at 1:50 pm, LN #14 was observed flushing Resident #18's dual lumen PICC (peripherally inserted central catheter) catheter located in the resident's right arm with heparin and normal saline. LN #14 entered the room and gloved his hands. LN #14 looked at the PICC catheter and decided he needed other supplies before flushing the catheter. LN #14 removed his gloves and left the room without washing his	F 441	assessment evaluates the nurse in multiple areas during medication administration including but not limited to proper handwashing or hand sanitizing related to medication administration. If areas of poor technique are identified then that nurse will receive individual in-service based on need and re-evaluated. The CQI Infection Control Nursing has been modified to include item to audit that staff are wearing gloves appropriately (not in hallways, change between resident cares, etc. and Staff demonstrate upon observation propoer hand hygiene practices related to direct patient cares. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Starting April 8, 2013, the Acting DNS will evaluate 4 nurses using the ISVH-L Medication Administration Skills Assessment per week x 4 weeks, then 4 nurses every other week x 2, then 4 nurses per month x 1, then 4 nurses will be evaluated quarterly. If areas of poor technique are identified then that nurse will receive individual in-service training based on need and re-evaluated. The Administrator will monitor the CQI Infection Control Nursing This CQI will be done q month x 3 months, then every three months x 6 months, then biannually. The CQI will start April 1, 2013 5. Date Corrective action will be completed: April 15,2013	

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F 441	Continued From page 79 hands. The LN came back into the room and regloved. LN #14, again, needed other supplies so he removed one glove, left the other glove on his hand and walked out of the resident's room without washing his hands or removing the other glove. LN #14 came back into the room, gloved the bare hand and flushed Resident #18's PICC catheter. After the procedure was completed, LN #14 removed his gloves and left the room without washing his hands. The LN was asked about washing his hands after removing his gloves and leaving the resident's room without removing his glove. He stated, "I washed my hands." The surveyor relayed the observations above. LN #14 had no other comments. On 2/15/13 at 1:00 pm, the Administrator and DON were informed of the observations. The facility provided no other information or documentation that resolved the concern.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of the facility's abuse investigations, review of the facility's policies and procedures on abuse, and record review, it was determined the Administrator, DON, and management team failed to manage the facility to ensure the safety and well being of	F 490	F 490 EFFECTIVE ADMINISTRATION/ RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 10, #16 and #17 were affected by this deficient practice. Based on review of the facility' s abuse policy, review of investigations, review of personnel files, record review and staff interviews it was determined that the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were immediately reported, residents were immediately protected, allegations were thoroughly investigated and appropriate corrective action was taken. Staff employed at the Idaho State Veterans Home - Lewiston who were involved with the alleged abuse of residents #10, #16 and #17 were placed on administrative leave while thorough investigations were conducted. LN #19 is no longer employed at the Idaho State veterans Home - Lewiston. LN # was notified by certified mail the conditions that she is allowed to visit her relative in order to maintain resident #17' s safety during her visits. Staff has been educated on the procedure of ensuring resident #17 is not in contact with former employee, LN #19,	

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F 490	Continued From page 80 each resident. They failed to immediately and thoroughly investigate allegations of abuse and report those allegations to the appropriate agencies. In addition, they failed to protect residents from further abuse. Also, they failed to develop comprehensive policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property and to operationalize policies and procedures to ensure residents were protected from abuse. These failed practices affected 3 sampled residents (#s 10, 16, 17) and had the potential to affect all residents residing in the facility. Specifically, the Administrator, DON, and management team failed to: 1. Ensure immediate and thorough investigations were conducted when allegations of staff-to-resident abuse were reported. This affected Resident #s 16 & 17. Refer to findings of immediate jeopardy at F225 for both residents. Refer to findings of harm to Resident #17 at F329. 2. Ensure residents were protected from further abuse when a staff member, who was terminated because of abusive behavior toward a resident (#17), was allowed to come back into the facility to visit a family member and/or co-workers without structured guidelines and/or supervision which resulted in upsetting Resident #17. Refer to findings of immediate jeopardy at F226. 3. Ensure the facility's policies and procedures regarding abuse were comprehensive and sufficient, according to Federal regulations at	F 490	while she is in the building. Leadership will monitor former employee, LN #19, while she is in the building to ensure she has no contact with resident #17. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential to be negatively impacted by this deficient practice. As a result, Reasonable Suspicion of a Crime Policy has been reviewed and revised to ensure consistency with Administrative Policy, State, and Federal Regulations. All of the staff were in-serviced regarding the deficient practice on February 28, 2013 and March 20, 2013 via multiple all staff meetings. Nursing staff received additional in-services on March 6, 7 & 8, 2013 and through silent in-services. All new allegations of abuse, neglect or mistreatment has been reported to State survey and certification agency. All individuals involved in the abuse allegation have been placed on administrative leave pending the outcome of the investigations. Results of the investigation have been reported to the State survey and certification agency. The Director of Social Services from Boise has conducted resident interviews of approximately 50% of the residents to identify concerns of abuse, neglect or mistreatment. No new issues were identified during this process. This same practice will be utilized for any staff discharged for abuse, neglect or mistreatment allegations and have family members residing in the ISVH Lewiston. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. All staff has been in-serviced regarding the updated policy and the behavioral expectations of reporting any alleged abuse, neglect or mistreatment of residents. Leadership has been transitioned to an interim staff to ensure the appropriate identification and investigation of alleged complaints of abuse, neglect or mistreatment. Future leadership will be extensively in-serviced regarding the behavioral expectations for reporting abuse allegations to all the appropriate agencies as well as Division staff to ensure that reporting requirements are met. Any identified failures to report abuse according to policy will be address as a performance issue with staff. Residents with behavioral concerns will have a behavior management plan and silent in-services will be used to reeducate the staff on behavior modification techniques. Staff have been in-serviced to the updated behavioral management plans for effective implementation. Social Service has had their policy manual extensively revised to address the current practice and expected professional practice. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The interventions and in-servicing by the interim staff have created an environment in which abuse allegations are reported by all staff. Future leadership staff will be extensively in-serviced to ensure understanding of the policy	

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F 490	Continued From page 81 F226, to ensure residents were not subjected to mistreatment, neglect, abuse, and misappropriation of their property. Refer to findings at F226. On 2/19/13 at 2:50 pm, the Administrator was informed of the concerns regarding the Administrative team. The facility provided no other information or documentation that resolved the concern.	F 490	and all behavioral expectations included in the policy. Idaho Division of Veterans Services staff will monitor this process on a monthly basis for the next 12 months through review of the reported polices, staff interviews, review of documentation to ensure policies are followed and abuse allegations are reported. 5. Date Corrective action will be completed: April 15,2013	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interviews, it was determined the facility failed to ensure all employees were sufficiently trained in emergency procedures for 3 of 3 employees (CNA #17, CNA #18, and LN #9) who were interviewed about emergency procedures. This resulted in the potential for employees to not respond in a safe or appropriate manner in the event of an emergency. The findings include: 1. The facility's Emergency Policies, undated, were reviewed. The policy titled Fire Procedure listed five steps that were to be followed during fire drills as well as an actual fire, as follows: - "Remove residents in immediate danger, calling	F 518	F 518 TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS This requirement was not met as evidenced by the determination that the facility failed to ensure all employees were sufficiently trained in emergency procedures for 3 of 3 employees. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. There was no resident affected by the deficient practice. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Facility staff from all departments (nursing, dietary, maintenance, activities, therapy and contract employees) were re-educated to the facility' s Emergency procedures. ISVH-L will schedule a Fire/Emergency in-service every month for the next three months, then every other month for six months, then quarterly to be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. BUILDING _____ B. WING _____	C 02/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE VETERANS HOME - LEWISTON	821 21ST AVENUE LEWISTON, ID 83501

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F 518	Continued From page 82 aloud repeatedly the code phrase DOCTOR RED IN (Location). If the fire is in a resident's room, evacuate that room and the rooms on either side of that room. Ensure that the doors are closed on those rooms." - "Immediately pull the fire alarm near the fire. Announce over the P.A. system, DOCTOR RED IN (Location)." - "Ensure all room doors in FIRE AREA are closed. Do not open a door if you think there is a fire behind it!" - "Report fire to charge nurse, who will in turn call the Fire Department (911) to verify that the Fire Department is en route." - "Return to Fire Area and attempt to extinguish the fire only if you can do so safely." During the survey, three employees were asked about the facility's emergency procedures with the following results: a. On 2/13/13 at 9:57 a.m., CNA #17 was asked what she was to do if there was a fire. CNA #17 stated she would close the doors and make sure residents were safe. CNA #17 stated she would then find out where the fire was. CNA #17 stated her instinct would be to yell "fire" but she would contact the charge nurse. CNA #17 stated she would then obtain oxygen bottles for residents and tell emergency personnel that oxygen was in use. CNA #17 was not able to verbalize the appropriate steps to be taken, as per the facility's	F 518	The CQI Facility Environment has been modified to include an item to verbally ask random staff what the ISVH-L facility procedures are in the event of an emergency (e.g. fire, flood···) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Facility Environment This CQI will be done q week x 4 weeks, then q month x 3 months, then every three months. The CQI will start March 25, 2013 5. Date Corrective action will be completed: April 15,2013	

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F 518	Continued From page 83 Fire Procedure policy. b. On 2/13/13 at 2:28 p.m., CNA #18 was asked what he was to do if there was a fire. CNA #18 stated he would check residents' location and make sure they were safe. He stated he would then locate the fire and alert everyone else. When asked about oxygen, CNA#18 stated he would make sure residents had an adequate supply of oxygen in their tanks. CNA #18 stated if the oxygen tank in the common area was empty, he would take the resident to a room with a wall hookup and close the door. When asked about evacuating from the facility, CNA #18 stated "We've never talked about that. I would grab a tank." When asked about the facility's Visitor Altercation code, CNA #18 stated "We haven't done a drill in a while. I keep a card in my wallet with the code but I don't keep my wallet on me at work." CNA #18 was not able to verbalize the appropriate steps to be taken, as per the facility's Fire Procedure policy. Additionally, CNA #18 was not able to express the steps to be taken if an actual evacuation was required and the facility's Visitor Altercation code. c. On 2/14/13 at 8:54 a.m., LN #9 was asked what her role was in the event of a fire. LN #9 stated she would direct CNAs to close doors and make sure everyone was safe. LN #9 stated she would then check the monitor at the nursing station to locate the fire. LN#9 stated if it was a false alarm, she would disable the system by pushing a series of three buttons. LN#9 stated if it was an actual fire, she would call 911 to verify emergency personnel were on their way. LN #9	F 518		

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F 518	Continued From page 84 stated if she located the fire, she would grab a fire extinguisher and put the fire out while CNAs were evacuating each room. LN#9 stated she would also get residents with oxygen away from the fire and shut off the oxygen. When asked which outlets in the facility were supplied by the backup generator, LN#9 stated she was not sure. LN #9 was not able to identify outlets supplied by the backup generator that would be necessary to know in an actual emergency. The facility failed to ensure all employees were sufficiently trained in emergency procedures.	F 518		

Bureau of Facility Standards

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	MDS001311	A. BUILDING: _____ B. WING _____	C 02/20/2013

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual state licensure survey of your facility. The surveyors conducting the survey were: Lynda Evenson, BSN, RN - Team Coordinator Nina Sanderson, BSW, LSW Ashley Anderson, QMRP Lorraine Hutton, RN	C 000	Annual Survey completed on February 20, 2013. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
C 107	02.100.02.b Written Policies/Procedures b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offe through arrangements with an outside service and of the operation of its physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations of both parties. This Rule is not met as evidenced by:	C 107	Please refer to Plan of Correction Form CMS-2567 F 490.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Acting Home Administrator — (X5) DATE: 3/22/13

Bureau of Facility Standards

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C 107	Continued From page 1 Please refer to F490 as it relates to management of the facility by the Administrator.	C 107		
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others; This Rule is not met as evidenced by: Please see F225 and F226 as it relates to resident abuse.	C 123	Please refer to Plan of Correction Form CMS-2567 F 225 and F 226.	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to resident dignity.	C 125	Please refer to Plan of Correction Form CMS-2567 F 241	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent	C 147	Please refer to Plan of Correction Form CMS-2567 F329	

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C 147	Continued From page 2 necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to the use of unnecessary medications.	C 147		
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS 05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Please refer to F518 as it relates to employee instruction in safety measures.	C 243	Please refer to Plan of Correction Form CMS-2567 F 518	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F441 as it relates to hand washing.	C 644	Please refer to Plan of Correction Form CMS-2567 F 441	
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the	C 664	C664 Required Members of Committee This requirement was not met as evidenced by the determination that the facility failed to ensure the Pharmacist attended the Infection Control Committee. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No resident was affected by the deficient practice.	

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C 664	Continued From page 3 Infection Control Meeting Minutes, it was determined the facility did not ensure the Pharmacist attended the Infection Control Committee. This had the potential to affect all residents, staff and visitors in the facility. Findings included: On 2/14/13 at 8:45 am, the Infection Control Nurse provided the Infection Control Meeting Minutes with the attendance sheets attached for the quarterly meetings on 7/24/12, 10/25/12 and 1/24/13. She said that during this meeting, Infection Control data was presented and discussed. The Attendance Record form documented who attended the meeting. The pharmacist signature was not on any of the attendance records. The Infection Control Nurse was asked if the pharmacist attended the meetings for the dates referenced above. She said, "No." There was no documentation that the pharmacist was excused from the meetings. The Administrator and DNS were informed of the finding on 2/20/13 at 2:30 p.m. The facility provided no other information or documentation that resolved the concern.	C 664	2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. The Pharmacist will attend the monthly Infection Control Meeting. CQI Infection Control Nursing has been modified to include an item to audit that all members of the Infection Control Committee have signed the meeting minutes. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Infection Control Nursing This CQI will be done q month x 3 months, then every three months x 6 months, then biannually. The CQI will start April 1, 2013 5. Date Corrective action will be completed: April 15,2013	
C 666	02.150.02,c Quarterly Committee Meetings c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure the minutes of the infection control committee had been signed by the Chairperson of the committee as required.	C 666	C666 Quarterly Committee Meetings This requirement was not met as evidenced by the determination that the facility failed to ensure the minutes of the infection control committee had been signed by the Chairperson of the committee. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No resident was affected by the deficient practice. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	

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C 666	Continued From page 4 This had the potential to affect all residents, staff and visitors to the facility. Findings include: The Infection Control Manual was reviewed on 2/14/13 at 8:45 am with the Infection Control Nurse. The Infection Control Nurse provided the minutes from the quarterly Infection Control Meetings, dated 7/24/12, 10/25/12 and 1/25/13. The meeting minutes were not signed by the Infection Control Nurse who was the chairperson the committee. The Infection Control Nurse said she did not sign any Infection Control Meeting Minutes. The Administrator and DON were informed of the finding on 2/20/13 at 2:30 pm. The facility provided no other information or documentation that resolved the concern.	C 666	All residents that reside in the facility are at risk for being affected by the deficient practice. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. CQI Infection Control Nursing has been modified to include an item to audit that all members of the Infection Control Committee have signed the meeting minutes, including the Chairperson of the committee. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Infection Control Nursing. This CQI will be done q month x 3 months, then every three months x 6 months, then biannually. The CQI will start April 1, 2013 5. Date Corrective action will be completed: April 15,2013	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to the revision of care plans.	C 782	Please refer to Plan of Correction Form CMS-2567 F 280	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by:	C 784	Please refer to Plan of Correction Form CMS-2567 F 309	

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C 784	Continued From page 5 Please see F309 as it relates to bowel care and pain relief.	C 784		
C 785	02.200,03,b,i Grooming Needs i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please refer to F312 as it relates to bathing.	C 785	Please refer to Plan of Correction Form CMS-2567 F 312	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F332 and F333 as it relates to medication administration.	C 798	Please refer to Plan of Correction Form CMS-2567 F 332 and F 333	
C 820	02.201,01,a a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications.	C 820	Please refer to Plan of Correction Form CMS-2567 F 428	

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C 820	Continued From page 6 This Rule is not met as evidenced by: Please refer to F428 as it relates to medication regimen review for omeprazole.	C 820		
C 838	02.201,02,I I. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist. This Rule is not met as evidenced by: Please refer to F281 and F431 as it relates to locking medications.	C 838	Please refer to Plan of Correction Form CMS-2567 F 281 and F 431	
C 875	02.202,03 EXAMINATION OF PETS 03. Examination of Pets. Pets shall receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations shall be given. Birds subject to transmission of psittacosis are included. This Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a pet bird received an examination by a veterinarian prior to admission to the facility. This had the potential to expose all residents (Residents #1 - #61) to health hazards. The findings include: During an observation at the facility on 2/12/13 from 12:32 - 1:00 p.m., two birds were noted to be in a cage located in the common area near the	C 875	C875 Examination of Pets This requirement was not met as evidenced by the determination that the facility failed to ensure a pet bird received an examination by a veterinarian prior to admission to the facility. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No resident was affected by the deficient practice. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents that reside in the facility are at risk for being affected by the deficient practice. 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Both facility birds were taken to the Veterinarian and have received clean bill of health on 2/28/13.	

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C 875	Continued From page 7 nurse's station. IDAPA 16.03.02.202.03 states "Pets shall receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations shall be given. Birds subject to transmission of psittacosis are included." When asked on 2/13/13 at 10:49 a.m. if the birds had received a physical examination from a veterinarian, the Activities Director stated there was no documentation that one of the birds had received an examination. The facility failed to ensure a pet bird received a physical examination prior to admission to the facility.	C 875	The facility birds will be taken annually to the veterinarian by the Activity Coordinator for annual 'checkup' and receive any recommend vaccines. Should ISVH-L decide to have any other facility pets then facility will ensure that those pets are seen by a veterinarian prior to admission. CQI Infection Control Nursing has been modified to include an item that audits that facility pets have been seen prior to admission and annually and that there is documentation to support. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Administrator will monitor the CQI Infection Control Nursing This CQI will be done q month x 3 months, then every three months x 6 months, then biannually. The CQI will start April 1, 2013 5. Date Corrective action will be completed: April 15,2013	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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April 16, 2013

Kenneth Shull, Interim Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501

Provider #: 135133

Dear Mr. Shull:

On **February 20, 2013**, a Complaint Investigation survey was conducted at Idaho State Veterans Home - Lewiston. Lynda Evenson, R.N., Lorraine Hutton, R.N., Nina Sanderson, L.S.W. and Ashley Anderson, Q.M.R.P. conducted the complaint investigation. This complaint was investigated in conjunction with the annual Recertification and State Licensure survey.

During the complaint investigation, the following were reviewed:

- The identified resident's medical records and hospital records; and
- Medical records for two additional residents identified in the complaint.

The following staff were interviewed:

- Acting Administrator;
- Acting Director of Nursing Services;
- Consulting Social Worker; and
- Infection Control Nurse.

Observations occurred throughout the survey of the day-to-day care of residents, staff interactions with residents and opportunities for staff to maintain or violate residents' confidentiality and privacy.

In addition, individual resident and family interviews and a resident group meeting were conducted during the survey. The residents and families were asked questions about general care, treatment by staff and protection of resident privacy and confidentiality. The residents attending the meeting, as well as the residents and families interviewed expressed no concerns regarding these issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005908

ALLEGATION #1:

The complainant stated the identified resident's condition rapidly deteriorated during his stay at the facility, between November 2, 2012, and December 28, 2012. The resident required hospitalization on nine different occasions during that time. When he was admitted to the hospital on December 2, 2012, the complainant said the resident was dehydrated, malnourished, had pneumonia, sepsis and was in septic shock.

FINDINGS:

Based on medical records reviewed and staff interviewed, it could not be determined that the facility's care resulted in a rapid decline in the identified resident's condition during his stay there. However, it was determined that the resident was admitted with swallowing problems, was at risk for aspiration pneumonia and had a physician's order for nectar thick fluids. The facility failed to document that liquid dietary supplements administered to the resident by licensed nursing staff were nectar thick in consistency. Please Refer to Federal Tag F309 cited on the February 20, 2013 survey report.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the Director of Nursing (DoN) was observed discussing the identified resident's case with another resident of the facility. The other resident was reportedly the DoN's mother. The complainant was concerned about issues of confidentiality for other patients in the facility, as well as the resident.

FINDINGS:

Based on resident and family interviews as well as observations, it could not be determined that residents' confidentiality or privacy were violated. No one interviewed had any recollection of seeing or hearing the identified resident's condition/case being discussed with other residents.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the POST (Idaho Physician Orders for Scope of Treatment form) was changed by the family during one of the patient's hospitalizations. The family approved a PEG tube, IV fluids and IV antibiotics. The complainant stated a copy of the POST sent to the facility, where the resident was transferred after his last hospital stay, was different from the last one viewed by the family at the facility. Although the dates on the POSTs were the same, what was marked under Artificial Fluids and Antibiotics differed, and the changes had not been signed or initialed. The complainant believes the facility altered the POST.

FINDINGS:

Based on review of the resident's medical record and staff interviews, it was determined there were two POSTs in the resident's closed record. Both were dated and signed on November 2, 2012, but contained conflicting information in Section C - Artificial Fluids and Nutrition and Antibiotic and Blood Products. The facility was cited at Federal Tag F155 for failure to initial and sign changes to the POST. Please Refer to the survey report dated February 20, 2013.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated on December 15, 2012, following the identified resident's discharge from the hospital, there was no diagnosis of Vancomycin Resistant Enterococcus (VRE). Yet on December 28, 2012, when the patient was readmitted to the hospital, he tested positive for VRE. The complainant believes the resident contracted VRE while in the facility.

FINDINGS:

The resident was readmitted to the facility on December 13, 2012, and discharged on December

28, 2012, fifteen days after his readmission. The resident's urine was cultured on December 15, 2012, and showed no growth of VRE. No further urine testing was done until the resident reentered the hospital on December 28, 2012. At that time, the resident did test positive for VRE. It is possible that the VRE was still in the incubation phase when tested by the facility on December 15, 2012, and was not predominant enough to show positive on a culture until later. The resident did not have documented signs of a urinary tract infection prior to his transfer to the hospital on December 28, 2012, for cellulitis.

Based on review of the monthly Infection Prevention Reports dated April 2012 through December 2012 and Quarterly Infection Control Reports dated July 24, 2012, October 25, 2012, and January 24, 2013, there were no cases of VRE in the facility between April 2012 and December 2012. In addition, there were no reported cases of VRE during the survey or in January 2013.

Because of the timeframes indicated above and the absence of VRE in the facility, there was insufficient evidence to determine if the identified resident's VRE infection was contracted during the resident's hospital stay between December 2, 2012, and December 13, 2012, or during his stay in the facility between December 13, 2012, and December 28, 2012.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated there have been five deaths in the facility between November 7, 2012, and December 12, 2012. One resident (name provided), fell in the shower, sustained a head injury and died as a result. Another resident (name provided) who had ALS, died from complications that the complainant felt could have been attributed to poor care. There were three other deaths according to the complainant, but the complainant was unable to recall names or circumstances.

FINDINGS:

Based on records reviewed and staff interviews, there was no evidence of deficient practice found on the part of the facility that contributed to the death of the two individuals identified in the complaint.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Loretta Todd

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj